

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

04554

1. PLACE OF DEATH

County BaltimoreRegistration Dist. No. 3Village or City CatonsvilleNo. Warne Nursing Home St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds.

How long in U. S. If of foreign birth? _____ yrs. _____ mos. _____ ds.

2. FULL NAME JOHN W. ABELL

If U. S. Veteran, specify WAR _____

(a) Residence: No. Smithwood Ave.

St. _____ Ward _____

(Usual place of abode)

If nonresident give city or town and State _____

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W5. SINGLE, MARRIED, WIDOWED,
OR DIVORCED (write the word)Single5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of _____

6. DATE OF BIRTH (month, day, end year)

Aug. 8, 1870

7. AGE

Years

Months

Days

If LESS than
1 day, _____ hrs.
or _____ min.8092

OCCUPATION

8. Trade, profession, or particular
kind of work done, as SPINNER,
SAWYER, BOOKKEEPER, etc.Unknown9. Industry or business in which
work was done, as SILK MILL,
SAW MILL, BANK, etc.10. Date deceased last worked at
this occupation (month and
year) _____11. Total time (years)
spent in this
occupation _____

12. BIRTHPLACE (city or town)

(State or country)

Md.443X

FATHER

13. NAME

George Abell93d

MOTHER

14. BIRTHPLACE (city or town)

(State or country)

Md.

15. MAIDEN NAME

Mary Benson

16. BIRTHPLACE (city or town)

(State or country)

Md.

17. INFORMANT

(Address)

Dr. Thos. L. L. Water
248 Madison St.

18. BURIAL, CREMATION, OR REMOVAL

Place

Cathedral

Date

5/12/1951

19. UNDERTAKER

(Address)

M. Faher & Sons401 SUFFOLK Rd. - 18

20. FILED

5/111951Atty. General

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

5/10/1951

(Month)

(Day)

1951
(Year)

22. I HEREBY CERTIFY, That I attended deceased from

April 7, 1949 to May 10, 1951I last saw him alive on May 8, 1951; death is saidto have occurred on the date stated above, at 11:59 A.M.

The PRINCIPAL CAUSE OF DEATH and related causes of importance

were as follows:

Broncho pneumonia, Terminal

Date of onset

May 8, 1951

Other Contributory Causes of importance:

Hypertensive Heart DiseaseAsthmatic BronchitisArteriosclerosis

Name of operation

N.D.

Date of

What test confirmed diagnosis? chest x-rays Was there an autopsy? no

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? noIf so, specify no

(Signed)

Randolph H. Spitzberg M. D.(Address) 5010 Darnmore Ave., Balt., Md.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>
Other contributory causes of importance:	
<i>Gallstones</i>	<i>May 1, 1923</i>

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>
Other contributory causes of importance:	
<i>Gastroenteritis</i>	<i>1 year</i>

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04555

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>2629 Joppa Road</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2629 Joppa Rd.</u>		STREET ADDRESS (If rural, give location) <u>2629 Joppa Road Baltimore</u>	
3. NAME OF DECEASED (Type or Print) <u>Elizabeth A. Altland</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>17</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Nov-24-1866</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housekeeping</u>	9. AGE last birthday <u>84 years 23 days</u>
11. BIRTHPLACE (State or foreign country) <u>York Co. Pa.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>William M. Anderson</u>		14. MOTHER'S MAIDEN NAME <u>Lidia Melt</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>William M. Altland 2629 Joppa Rd Baltimore</u>			

18. MEDICAL CERTIFICATION
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Cerebral hemorrhage

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from July, 1950, to 5-17-, 1951, that I last saw the deceased alive on 5-15-, 1951, and that death occurred at 9:20 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Rural</u>	<u>May 19-1951</u>	<u>Quaker's Cemetery</u>	<u>York Co</u>	<u>Pa.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>5/17/51</u>	<u>C. W. Hedrick</u>	<u>John Burns' Sons</u>	<u>Towson, Maryland</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

04556

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Middle River</u> LENGTH OF STAY (In this place) <u>4 hrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Chase</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ivy Hall Nursing Home</u>		STREET ADDRESS (If rural, give location) <u>Harcwood Park Rd.</u>	
3. NAME OF DECEASED (First) <u>Kate</u> (Middle) <u>Appel</u> (Last) <u>Appel</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>31</u> (Year) <u>1951</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>6/29/76</u>
9. AGE last birthday <u>74</u> yrs.		10. UNDER 1 year Months Days Hours Min. <u>74</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>W. VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>AUGUST NEIDEMEYER</u>		14. MOTHER'S MAIDEN NAME <u>LOUISE CARL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>MRS. LT. HENNELIN HARWOOD PK. DRIVE</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a) <u>Immediate cause</u> <u>422.1</u> <u>Congestive Heart Failure</u>		<u>1 month</u>
(b) <u>Antecedent cause(s)</u> <u>93d</u> <u>Arteriosclerotic Cardiovascular Disease</u>		
(c) <u>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>		

19. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Severe Anemia; Chronic ulcer of rt. leg.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>—</u>

22. I hereby certify that I attended the deceased from Feb., 1951, to May 31, 1951, that I last saw the deceased

alive on May 30, 1951, and that death occurred at 5:20 P. m., from the causes and on the date stated above.

SIGNATURE Charles M. Kern MD (Degree or title) ADDRESS 6801 Belair Rd. (G) DATE SIGNED 31 May 51

23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE THEREOF <u>6/4/51</u>	NAME OF CEMETERY OR CREMATORY <u>OAK LAWN</u>	LOCATION (City, town, or county) (State) <u>BALTIMORE CO MD</u>
DATE REC'D BY LOCAL REG. <u>6-4-51</u>	REGISTRAR'S SIGNATURE <u>—</u>	24. FUNERAL DIRECTOR <u>Blawan & Hoffman</u>	ADDRESS <u>1639 Broadway</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04557

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>	
TOWN <u>Arbutus</u>		TOWN <u>Arbutus</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5550 South Western Blvd</u>		STREET ADDRESS (If rural, give location) <u>5550 South Western Blvd</u>	
3. NAME OF DECEASED (First) <u>Marion</u> (Middle) <u>Bailey</u> (Last) <u></u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>6th</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>4/25/1886</u>
9. AGE last birthday <u>64</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of last year) <u>Clinical Work</u>	
11. BIRTHPLACE (State or foreign country) <u></u>		12. CITIZEN OF WHAT COUNTRY? <u></u>	
13. FATHER'S NAME <u>Lawrence C. Davis</u>		14. MOTHER'S MAIDEN NAME <u>Mary R. Weber</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY No. <u>212-26-2515</u>	
17. INFORMANT AND ADDRESS <u>Lawrence C. Davis Arbutus</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Sudden death - probable embolism

Antecedent cause(s)

(b) Chc. myocardiitis - 2 gradual decompensations(c) and edema

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN ONSET AND DEATH

1 or 2 weeks1 yr. +

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1950, to May 6, 1951, that I last saw the deceasedalive on May 5, 1951, and that death occurred at 11 A m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

04558

Reg. Dist. No. 41

1. PLACE OF DEATH COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE MD COUNTY BALTO.	
CITY (If outside corporate limits, write RURAL and give nearest town) DUNDALK		CITY (If outside corporate limits, write RURAL and give nearest town) DUNDALK, MD.	
TOWN DUNDALK		TOWN DUNDALK, MD.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Lynch Road -		STREET ADDRESS (If rural, give location) 6842 BROENING ROAD	
3. NAME OF DECEASED (Type or Print)	(First) JAMES	(Middle) PETER	(Last) BAKER, JR
4. DATE OF DEATH	(Month) 5	(Day) 24	(Year) 1957
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH 3-16-1927
			9. AGE last birthday 24 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRESS HAND		10b. KIND OF BUSINESS OR INDUSTRY RADIO-TELEVISION	
11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME JAMES P. BAKER, SR		14. MOTHER'S MAIDEN NAME LOUISE R. WHITE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY No. 214-20-5993	
(If yes, give war or dates of service) WW II		17. INFORMANT JAMES P. BAKER, SR.	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Carbon-Monoxide Poisoning			
Antecedent cause(s) (b) (Automobile & Laws)			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office, etc.) Home	
TIME (Month) (Day) (Year) (Hour) OF INJURY 11:30 AM		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		HOW DID INJURY OCCUR? None	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE W. Davis MD		DATE SIGNED 5/28/57	
23. BURIAL, CREMATION REMOVAL (Specify) BURIAL		DATE THEREOF 5/28/57	
NAME OF CEMETERY OR CREMATORY BALTO. NATIONAL		LOCATION (City, town, or county) (State) BALTO, MD.	
DATE REC'D BY LOCAL REG. May 27-1957		24. FUNERAL DIRECTOR Walter Brooks Bradley, Dundalk, MD	
REGISTRAR'S SIGNATURE William M. Kelly		ADDRESS 690 806	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 28 1961
BUREAU - U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04559

CERTIFICATE OF DEATH

Reg. Dist. No. 58

1. PLACE OF DEATH:

County Baltimore
City or town Baltimore (Parkville)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

2916 Chenoak

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 2916 Chenoak
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Henry Carl Ballweg

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MALE White MARRIED6. (b) Name of husband or wife Catherine V.7. Birth date of deceased (mo., day, yr.) OCT. 26, 1905 6. (c) If alive, give age years8. AGE: Years 45 Months Days If less than one day hrs. min.9. Birthplace New York
(Town, county, and state)10. Usual occupation SALESMAN - Pepsi Cola

11. Industry or business

12. Name Henry J. Ballweg13. Birthplace N.Y.14. Maiden name Katherine Snyder

15. Birthplace

16. Informant Mrs. Catherine V. BallwegAddress 2916 Chenoak17. Burial Date thereof 5-31-51
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Moreland Mem. ParkLocation Baltimore - Md18. Funeral director L. J. RuckAddress 5305 Hartford Road19. 5/28 19 51 A. W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 19 51 at 4:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Medical Examiners Case 19

and that I last saw h. alive on 19

Immediate cause of death

Coronary Occlusion

DURATION

Sudden

Due to

Due to 420.1

Other conditions

94a

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas. Green M. D. or otherAddress Louisa, 4 Md Date signed 5/27/51(Deputy Medical Examiner) 49060

MARGIN RESERVED FOR BINDING

VS A15 T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

04560

Reg. Dist. No. 38

1. PLACE OF DEATH COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md</u> COUNTY <u>Balto</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				CITY (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>N. York Rd</u>				STREET ADDRESS (If rural give location) <u>N. York Rd</u>			
3. NAME OF DECEASED (Type or Print) <u>Nellie</u> (First) <u>FRANCES</u> (Last) <u>Batty</u>				4. DATE OF DEATH Month <u>May</u> Day <u>21</u> Year <u>1951</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>C</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>m</u>		8. DATE OF BIRTH <u>3/25/82</u>	
9. AGE last birthday <u>69</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Matthews Co. Va</u>	
13. FATHER'S NAME <u>Robert Foster</u>				14. MOTHER'S MAIDEN NAME <u>Jane?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Thomas Batty - Towson Md</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Heart disease, vascular, coronary occlusion</u>							
Antecedent cause(s) (b) <u>420.1</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>94a</u>							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY				INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .							
SIGNATURE <u>Rollin B. Hudson M.D., DME.</u>				ADDRESS <u>Towson 4 Md</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>				DATE THEREOF <u>5/24/51</u>		NAME OF CEMETERY OR CREMATORY <u>Pleasant Rest Cem</u>	
DATE REC'D BY LOCAL REG <u>5/22/51</u>				REGISTRAR'S SIGNATURE <u>T</u>		24. FUNERAL DIRECTOR <u>Samuel W. Sullivan Jr - Balto. Md.</u>	
						DATE SIGNED <u>5/21/51</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04561

Reg. Dist. No. 37

1. PLACE OF DEATH- COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Reisterstown</u> LENGTH OF STAY (in this place) <u>life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Reisterstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rural Route 1 Box 67</u>		STREET ADDRESS (If rural give location) <u>R.R. #1 Box 67 (Dover Rd)</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>SAAC</u> <u>BAUBLITZ</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>MAY</u> <u>11</u> <u>1951</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Nov 28, 1879</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	9. AGE last birthday <u>71</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Balto Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Jeremiah Baublitz</u>		14. MOTHER'S MAIDEN NAME <u>Mary Frank</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Wm. A. Koerner 716 W. Madison St.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) BRONCHO - PNEUMONIA

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) ARTERIOSCLEROTIC C.V. DISEASE WITH AURICULAR FIBRILLATION AND CARDIAC DECOMPENSATION

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from JUNE, 1951, to MAY 11, 1951, that I last saw the deceased alive on MAY 10, 1951, and that death occurred at 8:15 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>5-14-51</u>	<u>Graceland</u>	<u>Reisterstown</u>	<u>Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>May 12/51</u>	<u>Wm. J. Shickel</u>	<u>J. Scott Brooks</u>	<u>Sparks, Md.</u>	

50
76
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REAU V. B.
1979 TO 1981

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

04562

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fort Howard</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hosp.</u>		STREET ADDRESS (If rural, give location) <u>627 Colorado Ave.</u>	
3. NAME OF DECEASED (Type or Print) <u>ANDREW J. BEAUCHAMP</u>		4. DATE OF DEATH <u>May 4 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>4-24-97</u>
9. AGE last birthday <u>54</u> yrs.		10. DATE OF BIRTH <u>4-24-97</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired-Navy Service</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel O. Beauchamp</u>		14. MOTHER'S MAIDEN NAME <u>Jane E. Bond</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes WWII</u>		16. SOCIAL SECURITY NO. <u>212-18-9609</u>	
17. INFORMANT AND ADDRESS <u>Clin. Rec., Vet. Adm. Hosp. Ft. Howard, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Cardiac Hypertrophy & Dilatation

INTERVAL BETWEEN ONSET AND DEATH

unknown

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Coronary arteriosclerosis
Old cerebral hemorrhage lt.

unknown
3 yrs.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 3....., 1951, to, May 4....., 1951, and that death occurred at 7:05 P.m., from the causes and on the date stated above.

SIGNATURE William Scheue (Degree or title)

ADDRESS DATE SIGNED

WILLIAM SCHEUE, M.D. VETERANS ADMINISTRATION FORT HOWARD, MD.

5-5-51

23. BURIAL CREMATION REMOVAL (Specify) DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)

Burial
DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Betram, Gore Funeral Home Chas. & 23rd Sts.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04563

Reg. Dist. No. 33

1. PLACE OF DEATH COUNTY Baltimore		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Reisterstown		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Reisterstown	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Stocksdale Ave		STREET ADDRESS (If rural give location) Stocksdale Ave	
3. NAME OF DECEASED (Type or Print)	(First) Ida	(Middle) Irene	(Last) Benson
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	4. DATE OF DEATH (Month) May (Day) 18 (Year) 1951
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	8. DATE OF BIRTH June 15 1860
13. FATHER'S NAME William Gore		11. BIRTHPLACE (State or foreign country) Maryland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		12. CITIZEN OF WHAT COUNTRY? USA	
16. SOCIAL SECURITY No. None		14. MOTHER'S MAIDEN NAME Sarah Alvena Stocksdale	
17. INFORMANT Mrs Oliver Warner Reisterstown Md		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) Coronary thrombosis			
Antecedent cause(s) (b) arteriosclerosis general			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) hypertension & myocarditis			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
HOW DID INJURY OCCUR?		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from 1-1-38 , to 5-18-51 , that I last saw the deceased alive on 5-18-51 , and that death occurred at 11 P m., from the causes and on the date stated above.			
SIGNATURE Dary B. Eline		ADDRESS Reisterstown, Md	
DATE SIGNED 5/21/51			
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF May 22 1951	
NAME OF CEMETERY OR CREMATORY Reisterstown Meth Com		LOCATION (City, town, or county) (State) Md	
DATE REC'D BY LOCAL REG. 5-21-51		24. FUNERAL DIRECTOR Wm Berryman & Sons Reisterstown Md	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

04564

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Granite</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Granite</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hernwood Road</u>		STREET ADDRESS (If rural, give location) <u>Hernwood Road</u>	
3. NAME OF DECEASED (Type or Print) <u>Thomas Ringgold Blunt</u>		4. DATE OF DEATH <u>May 17 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Mch. 9, 1893</u>
9. AGE last birthday <u>58</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stone Worker</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Bradley T. J. Blunt</u>		14. MOTHER'S MAIDEN NAME <u>Laura Dorsey Worthington</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>17-18</u>		16. SOCIAL SECURITY No. <u>218-14-5017</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Thomasine A. Blunt (Wife)</u>			

18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Suicide by hanging</u>	<u>1 hr.</u>
Antecedent cause(s) (b) <u>Mentally Depressed</u>	<u>10 mos.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing in the death but not related to the disease or condition causing death. <u>None</u>	
19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION <u>None</u>
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) <u>None</u>
TIME (Month) (Day) (Year) (Hour) <u>May 17, '51-2p.m.</u>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>
HOW DID INJURY OCCUR? <u>Hung himself in kitchen</u>	(CITY OR TOWN) <u>Granite</u> (COUNTY) <u>Balto.</u> (STATE) <u>Md.</u>

22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input checked="" type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .	
SIGNATURE <u>D. D. Caples, Deputy Med. Exam. Md.</u>	DATE SIGNED <u>5-17-'51</u>
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	DATE THEREOF <u>May 10 1951</u>
NAME OF CEMETERY OR CREMATORY <u>Purata Burial Home</u>	LOCATION (City, town, or county) <u>Granite, Balto. Co. Md.</u>
DATE REC'D BY LOCAL REG. <u>May 19, 1951</u>	REGISTRAR'S SIGNATURE <u>R.W.</u>
FUNERAL DIRECTOR <u>Charles Lamoreaux</u> ADDRESS <u>4510 Liberty Bldg. Balto.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. CCX

04565

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Fort Howard</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 31</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hosp.</u>		STREET ADDRESS (If rural, give location) <u>1300 E. Lexington Street</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>WILLIE</u> (Middle) <u>F.</u> (Last) <u>BOSTIC</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>16</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1-19-09</u>
9. AGE last birthday <u>42</u> yrs.		10. If under 1 year Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>Edgefield, South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY No. <u>Unknown</u>	
17. INFORMANT AND ADDRESS <u>Clin.Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>CEREBRAL EDEMA</u>			<u>UNKNOWN</u>
Antecedent cause(s) (b) <u>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>			
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Trephine of skull, May 14, 1951 - for possible brain</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>tumor - none found at operation (5/28/51 akc)</u>	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office hldg., etc.) <u>HOMICIDE</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that <u>VA</u> attended the deceased from <u>April 25, 1951</u> , to <u>May 16, 1951</u> , and that death occurred at <u>3:10 P.</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Irving Freeman</u>		ADDRESS <u>Baltimore</u>	
DATE SIGNED <u>5-17-51</u>			
IRVING FREEMAN, M. D., ACTING CHIEF, MEDICAL SERVICE, VAH, FORT HOWARD, MD.			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>5/21/1951</u>	
NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>Elroy O. Wilson</u>		ADDRESS <u>1000 Brantley Ave. Baltimore, Maryland</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3409/6

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 2 38

04566

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural: Towson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eudowood Sanatorium Towson 4, Maryland</u>		STREET ADDRESS <u>1717 N. Montford Ave</u>	
3. NAME OF DECEASED (First) <u>Hugh Dennis</u> (Middle) <u>Bradley</u> (Last)		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>6</u> (Year) <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>July 16, 1888</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machine</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>62</u> yrs. <u>7</u> under 1 year <u>1</u> under 24 hrs. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Denis Bradley</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Johny</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-07-9220</u>	
17. INFORMANT AND ADDRESS <u>Personal History- Hospital Records, Eudowood Sanatorium</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Pulmonary tuberculosis

INTERVAL BETWEEN ONSET AND DEATH

6 years

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 16, 1949, to May 6, 1957, that I last saw the deceased

alive on May 6, 1957, and that death occurred at 5 P.M. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

William A. Bridge

M.D., Eudowood Sanatorium, Towson 4, Maryland

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE RECD BY LOCAL REG

REGISTERAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

5/8/57

May 9, 1957

St Johns

Long Green Md

Leo S. Leach 1703 N. Patterson Park

Don

544 W. ave

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. ~~XX~~

1. PLACE OF DEATH- COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) Fort Howard		CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hosp.		STREET ADDRESS (If rural, give location) 2679 Wilkens Avenue	
3. NAME OF DECEASED (Type or Print) ADDISON (First) T. (Middle) BRAMHALL (Last)		4. DATE OF DEATH (Month) May (Day) 21 (Year) 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 6-1-95
9. AGE last birthday 55 yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Breakman		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Lovettsville, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Bramhall		14. MOTHER'S MAIDEN NAME Gertrude Baker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT AND ADDRESS Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		UNKNOWN	
Immediate cause (a) CEREBRAL HEMORRHAGE			
Antecedent cause(s) (b) NONE			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. NONE			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that VA attended the deceased from May 21 , 19 51 , to May 21 , 19 51 , and that death occurred at 12:08 P.m. , from the causes and on the date stated above.			
SIGNATURE Irving Freeman		ADDRESS VAH, FORT HOWARD, MD.	
DATE SIGNED 5-21-51		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (Specify) 5/24/51		NAME OF CEMETERY OR CREMATORY Union Cem.	
DATE REC'D BY LOCAL REG. 5/22/51		24. FUNERAL DIRECTOR Wm. J. Tickner & Sons	
REGISTRAR'S SIGNATURE B.W. Raduech		LOCATION (City, town, or county) (State) Lovettsville, Virginia	
		ADDRESS North & Pa. Aves. Baltimore, Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

5802 HALWYN AVE.

04568

31

1. PLACE OF DEATH COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>BALTO</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>WOODLAWN.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>WOODLAWN</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>AUGSBURG HOME.</u>		STREET ADDRESS (If rural, give location) <u>6811 CAMPFIELD Rd.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>SUSIE</u> (Middle)	(Last) <u>BRIEST</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>MAY 15 1951</u>
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW.</u>	8. DATE OF BIRTH <u>5/7/1866</u>
9. AGE last birthday <u>85</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE.</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTO. Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>MICHAEL SMITH.</u>		14. MOTHER'S MAIDEN NAME <u>ELIZ. MASCHERT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>RECORDS AUGSBURG HOME</u>	
17. INFORMANT AND ADDRESS <u>CAMPFIELD Rd.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Cerebral Hemorrhage

INTERVAL BETWEEN ONSET AND DEATH

2 days

Antecedent cause(s)

(b) Arterio - Sclerotic Heart Disease

5 yrs.

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c) Generalized Arterio - Sclerosis.

No.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from May - 1948, to May - 15, 1951, that I last saw the deceased alive on May - 10, 1951, and that death occurred at 9 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Carl L. Chambers M.D. 4108 Liberty Hts. Baltimore - 7. Md.

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>BURIAL</u>	<u>5/17/51</u>	<u>PARKWOOD</u>	<u>BALTO.</u>	<u>Md.</u>

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
<u>5-16-51</u>	<u>[Signature]</u>	<u>Carl Neumann 6061 Hayford Rd</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04569

Reg. Dist. No. 33

1. PLACE OF DEATH- COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Reisterstown		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Reisterstown	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Hanover Road		STREET ADDRESS (If rural, give location) Hanover Road	
3. NAME OF DECEASED (Type or Print)	(First) Edward	(Middle) L.	(Last) Brillhart
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Nov. 9, 1860
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired manager of supply company		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 90 yrs.
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Jacob Brillhart		14. MOTHER'S MAIDEN NAME Elizabeth Venus	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY No. None	
17. INFORMANT Sue I. Brillhart, Reisterstown, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a) *Myocarditis + Chronic + decompensatory*
(b) *hypertension*
(c) *arteriosclerosis*

INTERVAL BETWEEN ONSET AND DEATH
2 yrs
years
years

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify) <input checked="" type="checkbox"/>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <input checked="" type="checkbox"/> INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-1-30 to 5-21-57, that I last saw the deceased

alive on 5-21-57, 1957, and that death occurred at 11:54 a.m., from the causes and on the date stated above.

SIGNATURE *[Signature]* (Degree or title) ADDRESS *Reisterstown Md* DATE SIGNED *5-22-57*

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF May 24, 1951	NAME OF CEMETERY OR CREMATORY Druid Ridge	LOCATION (City, town, or county) (State) Pikesville, Md.
DATE REC'D BY LOCAL REG. 5-23-57	REGISTRAR'S SIGNATURE <i>Mary B. Eline</i>	24. FUNERAL DIRECTOR J.F. Eline & Sons, Reisterstown, Md.	ADDRESS

390 VVV

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAY 28 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

04570

Reg. Dist. No. *XX*

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fort Howard</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Vets. Adm. Hosp. Ft. Howard, Md.</u>		STREET ADDRESS (If rural, give location) <u>711 N. Fremont Ave.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>WILLIAM</u> (Middle) <u>A.</u> (Last) <u>BRISCOE</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>May 22 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>married</u>	8. DATE OF BIRTH <u>12-29-24</u>
9. AGE last birthday <u>26</u> yrs.		10. If under 1 year: Months <u> </u> Days <u> </u> Hours <u> </u> Mins. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer - Palapser Scrap Company</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Briscoe</u>		14. MOTHER'S MAIDEN NAME <u>Alberta Briscoe</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes WW-2</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Clin. Rec. Vets. Adm. Hosp. Ft. Howard, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) DECEASED DURING/ FURTHER/ SICK/ AT/ MEDICAL/ EXAMINER/

Antecedent cause(s)

(b) Central necrosis of the Liver, probably due to the ingestion of alcohol.

(c)

(6-8-51 - ams)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☒.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Eugene Mayo 609 George St. Balto. Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

D.M.

970626

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04571

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u> LENGTH OF STAY (In this place) <u>Abt 1 yr</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Elmhurst Home</u>		STREET ADDRESS (If rural, give location) <u>Edmondson Ave.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Margaret</u>	(Middle) <u>Louise</u>	(Last) <u>Bristor</u>
4. DATE OF DEATH	(Month) <u>May</u>	(Day) <u>20</u>	(Year) <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Nov-18-1866</u>
			9. AGE last birthday <u>84</u> yrs. If under 1 year: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Teacher</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William B. Bristor</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Tarr</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT <u>W.B. Bristor (nephew)</u>		<u>Towson, Md.</u>	

18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Hepatic Insufficiency</u>	<u>?</u>
Antecedent cause(s) (b) <u>Metastasis from Breast Carcinoma</u>	<u>?</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>ant. scl. Cardio Vasc. Dis.</u>	<u>?</u>
<u>Carcinoma of Breast</u>	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from March, 1951, to May 15, 1951, that I last saw the deceased alive on May 15, 1951, and that death occurred at 9 a.m., from the causes and on the date stated above.

SIGNATURE K. J. Gulevitz ADDRESS 244 N. Hilton St DATE SIGNED 5/21/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>May-22-51</u>	NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	LOCATION (City, town, or county) <u>Baltimore</u>
DATE REC'D BY LOCAL REG. <u>6/21/51</u>	REGISTRAR'S SIGNATURE <u>R. W. Hedrich</u>	24. FUNERAL DIRECTOR ADDRESS <u>Stewart-Mowen Co. 108-W-North-Balto. Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

04572

1. PLACE OF DEATH- COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Fort Howard		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Baltimore 17	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hosp.		STREET ADDRESS (If rural, give location) 1027 Eutaw Street	
3. NAME OF DECEASED (Type or Print)	(First) HUBBARD	(Middle) H.	(Last) BROWN
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	4. DATE OF DEATH (Month) May (Day) 13 (Year) 19 51
8. DATE OF BIRTH 4-10-21	9. AGE last birthday 30 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sugar Refinery - Machine Operator	
11. BIRTHPLACE (State or foreign country) S. Boston, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Brown		14. MOTHER'S MAIDEN NAME Rosa Hubbard	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY No. Unknown	
17. INFORMANT AND ADDRESS Clin. Rec., Vet. Adm. Hosp., Ft. Howard			

18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	
Immediate cause PULMONARY TUBERCULOSIS, CHRONIC, BILATERAL, ACTIVE FAR ADVANCED	INTERVAL BETWEEN ONSET AND DEATH Unknown
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 13b	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **March 16, 1949**, to **May 13, 1951**, that I saw the deceased **live** and that death occurred at **7:58 A.M.**, from the causes and on the date stated above.

SIGNATURE Irving Freeman	(Degree or title) M.D., ACTING CHIEF, MEDICAL SERVICE, VAH, FORT HOWARD, MD.	ADDRESS 5-14-51
23. BURIAL, CREMATION REMOVAL (Specify) Removal	DATE THEREOF 5/20/51	NAME OF CEMETERY OR CREMATORY Sunflower Cemetery
LOCATION (City, town, or county) Nathalie, Virginia	(State) VA	
DATE REC'D BY LOCAL REG. 5/18/51	REGISTRAR'S SIGNATURE a. w. Hubbard	24. FUNERAL DIRECTOR Charles R. Law
ADDRESS 802 Madison Avenue		Baltimore, Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

690419

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

04573

Reg. Dist. No. 45

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Baltimore</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Duncan</u>	
TOWN <u>Essex</u>		TOWN <u>Duncan</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>125A. Norris Lane</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Harper Boyd Burns</u>		4. DATE OF DEATH <u>May 14 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan 23/1886</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Painter</u>	9. AGE last birthday <u>65</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>West Fair View Penn.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Charles W Burns</u>		14. MOTHER'S MAIDEN NAME <u>Ella S. Cannon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>W. D. Wickman</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Fell down steps.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Fractured neck

(c)

INTERVAL BETWEEN ONSET AND DEATH

2 hrs.

II. OTHER SIGNIFICANT CONDITIONS
 Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>5 14 1951</u>		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Fell down cellar steps.</u>		

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF	NAME OF CEMETERY OR CREMATION	LOCATION (City, town, or county)	(State)
<u>Removal</u>		<u>May 17-1951</u>	<u>Int. Olivet</u>	<u>New Cumberland</u>	<u>Pa.</u>
DATE REC'D BY LOCAL REG. <u>May 14, 1951</u>		REGISTRAR'S SIGNATURE <u>Carl Hurley</u>		24. FUNERAL DIRECTOR <u>John J. Connelly</u> ADDRESS <u>Essex 21-Ind.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 16 1951
BIRMINGHAM

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

04574

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> TOWN <u>Catonsville</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> TOWN <u>Baltimore</u> STREET ADDRESS (If rural give location) <u>3013 Belair Road</u>	
3. NAME OF DECEASED (Type or Print) <u>Theresa Loretta Pietroff Campbell</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>18</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>7/15/1897</u>
9. AGE last birthday <u>53</u> yrs. <u>10</u> Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Henry Pietroff</u>		14. MOTHER'S MAIDEN NAME <u>Anna Holzschuh</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Hospital Records, Catonsville 28, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a)

Antecedent cause(s) (b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS
 Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION OR OTHER DISPOSITION (Specify) <u>Burial</u>	DATE THEREOF <u>5/21/51</u>	NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>	LOCATION (City, town, or county) <u>Balto Md</u>	(State) <u>MD</u>
DATE REC'D BY LOCAL REG. <u>5/21/51</u>	REGISTRAR'S SIGNATURE <u>W. W. Redish</u>	24. FUNERAL DIRECTOR <u>W. J. Luck</u>	ADDRESS <u>5305 Hayford Rd</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Item 18 on:

No. G 132 MAY 15 1951

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04575

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Catonsville		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Baltimore	
HOSPITAL OR INSTITUTE OR STREET ADDRESS Hood Nursing Home 5313 Edmondson Ave		STREET ADDRESS (If rural give location) 3 S. Franklintown Road	
3. NAME OF DECEASED (First) (Middle) (Last) Sylvester F. Carman		4. DATE OF DEATH (Month) (Day) (Year) May 5th, 1951	
5. SEX Male	6. COLOR OR RACE White	7. STATUS WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH Nov 21-1871
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pressman		10b. KIND OF BUSINESS OR INDUSTRY U.S.G. Print Office	9. AGE last birthday 79 yrs.
13. FATHER'S NAME Caleb Clinton Carman		14. MOTHER'S MAIDEN NAME Anna E. Foard	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY No. None	
17. INFORMANT Clinton S.E. Carman		12. CITIZEN OF WHAT COUNTRY U.S.	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		14. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Senility		cerebral thrombosis	3 1/2 mos 1/6 1/4 d.
Antecedent cause(s) (b) cerebral arteriosclerosis			15 1/2 mos.
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) (5/15/51 aka)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Jan. 20, 1950, to May 5, 1951, that I last saw the deceased alive on May 1, 1951, and that death occurred at 10:45 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE May 9-1951	NAME OF CEMETERY OR CREMATORY Loudon Park	LOCATION (City, town, or county) Baltimore Md	(State)
DATE REC'D BY LOCAL REG 5/7/51		REGISTRAR'S SIGNATURE R.W. Hedrick		24. GENERAL DIRECTOR Benjamin GORE	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04576

Reg. Dist. No. 32

1. PLACE OF DEATH- COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Mt. Wilson		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Arbutus	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Mt. Wilson State Hospital		STREET ADDRESS (If rural, give location) 1301 Linden Ave.	
3. NAME OF DECEASED (Type or Print)	(First) John	(Middle) Edward	(Last) Catitton
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 2/25/1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Railroad	9. AGE last birthday 58 yrs.
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME John Catitton		14. MOTHER'S MAIDEN NAME Florence Holaway	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT AND ADDRESS John E. Catitton, 1301 Linden Ave. Arbutus, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) **Carcinoma of Bronchus, primary; with metastasis to the lung.**

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) **Tuberculosis, pulmonary.**

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Tuberculosis, pulmonary (5/17/51 a/c)

19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE None		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY None		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **4/2** 19**51**, to **5/6** 19**51**, that I last saw the deceased alive on **5/6** 19**51**, and that death occurred at **2:37** p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

William Newcomer**M.D. Mt. Wilson, Md.****5/6/51**

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL		DATE THEREOF 5/9/51	NAME OF CEMETERY OR CREMATORY Meadow Ridge Memorial	LOCATION (City, town, or county) Wash. Blvd., Balto., Md.	(State)
DATE REC'D BY LOCAL REG. 5/6/51		REGISTRAR'S SIGNATURE Nelen R. Mayer		24. FUNERAL DIRECTOR R.C. & B. M. Walters, Pratt & Stricker Sts., Balto. Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 10 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04577

Reg. Dist. No. 42

1. PLACE OF DEATH COUNTY <u>Balto.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Balto.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Balto.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2804 Louisiana Ave</u>		STREET ADDRESS (If rural give location) <u>2804 Louisiana Ave</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Richard</u>	(Middle) <u>Thomas</u>	(Last) <u>Chenoweth</u>
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Sept 10, 1875</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Car Repairman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.O.R.R.</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Arthur Chenoweth</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Schwartz</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Richard Chenoweth, (Same)</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>2 day</u> <u>5 years</u>
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Cerebral Thrombosis</u>	Antecedent cause(s) (b) <u>Arteriosclerosis C.V.D.</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>93d</u>		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
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21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from April 1, 1951, to May 3, 1951, that I last saw the deceased alive on May 1, 1951, and that death occurred at 8 m., from the causes and on the date stated above.

SIGNATURE Paul Delaney ADDRESS 7301 Campbell DATE SIGNED 5/3/51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE <u>5/7/51</u>	NAME OF CEMETERY OR CREMATORY <u>Fork M. & Cem.</u>	LOCATION (City, town, or county) <u>Fork</u>	(State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>5/4/51</u>	REGISTRAR'S SIGNATURE <u>W. Hedrick</u>	24. FUNERAL DIRECTOR <u>Mildred J. Blight</u>	ADDRESS <u>6009 Harford Rd</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

FILM No. G 133 MAY 21 1951

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04578

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH. COUNTY <u>Balto.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u> TOWN <u>Woodlawn</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5802 Gwynn Oak Ave.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE <u>Md.</u> COUNTY <u>Balto.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u> TOWN <u>Woodlawn</u> STREET ADDRESS (If rural, give location) <u>5802 Gwynn Oak Ave.</u>	
3. NAME OF DECEASED (Type or Print) <u>MARIETTA</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>10</u> (Year) <u>1951</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>July 26, 1870</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	9. AGE last birthday <u>70</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Samuel N. Grim</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Sherman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Mr. Charles M. Reinhardt-5802 Gwynn Oak Ave</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

171X Immediate cause (a) Carcinoma of Cervix
 Antecedent cause(s) (b) Carcinoma of Cervix
 Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last (c) Generalized Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 5-9, 1950, to 5-9, 1951, that I last saw the deceased alive on 5-9, 1951, and that death occurred at 11 A. Am., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>5/14/51</u>	NAME OF CEMETERY OR CREMATORY <u>Meadowridge Mem. Pk.</u>	LOCATION (City, town, or county) <u>Elkridge, Md.</u>	(State) <u>Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE <u>Wm. J. Schuler</u>	24. FUNERAL DIRECTOR <u>Wm. J. Schuler & Sons</u>	ADDRESS <u>Balto Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04579

Reg. Dist. No. 4X

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Vet. Adm. Hosp., Ft. Howard, Md.</u>		STREET ADDRESS (If rural, give location) <u>3419 Harford Rd.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>LOUIS</u> (Middle) <u>C</u> (Last) <u>COUNIOTES</u>	4. DATE OF DEATH	(Month) <u>May</u> (Day) <u>5</u> (Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH <u>5/15/97</u>
9. AGE last birthday <u>53</u> yrs.		10. a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>	10. b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>
11. BIRTHPLACE (State or foreign country) <u>Greece</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Christopher Couniotes</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY No. <u>213-10-1619</u>	
17. INFORMANT AND ADDRESS <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>CARDIAC DILATATION & HYPERTROPHY</u>		<u>UNKNOWN</u>	
Antecedent cause(s) (b) <u>434.3</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>95c</u>			
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>CORONARY ARTERIOSCLEROSIS</u>		<u>UNKNOWN</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that <u>VA</u> attended the deceased from <u>1:30 a.m.</u> , 19 <u>51</u> , to <u>11:57 p.m.</u> , 19 <u>51</u> . <u>May 5</u> and that death occurred at <u>11:57 p.m.</u> , from the causes and on the date stated above. SIGNATURE <u>P.S. Stonestier, M.D.</u> ADDRESS <u>VAH, Fort Howard, Maryland</u> DATE SIGNED <u>5/6/51</u>			
23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or country) (State)
<u>Burial</u>	<u>May 9, 1951</u>	<u>Greek Cemetery</u>	<u>Baltimore, Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	2. FUNERAL DIRECTOR	ADDRESS
<u>5/7/51</u>	<u>Rev. Redund</u>	<u>Ellsworth Wmace</u>	<u>40 E. North Avenue</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

2546 77

MARYLAND STATE DEPARTMENT OF HEALTH

04580

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 33

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> <u>Baltimore</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Owings Mills</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Owings Mills</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pleasant Hill Road</u>		STREET ADDRESS <u>Pleasant Hill Road</u> (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Tibitha</u>	(Middle) <u>I</u>	(Last) <u>Cox</u>
4. DATE OF DEATH	<u>May 10, 1951</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, <u>Married</u> (Specify)	8. DATE OF BIRTH <u>Nov. 24, 1903</u>
9. AGE last birthday <u>47 yrs</u>		If under 1 year Months <u> </u> Days <u> </u>	If under 24 hrs Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	11. BIRTHPLACE (State or foreign country) <u>Reisterstown, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Uriah P. Cox</u>	
14. MOTHER'S MAIDEN NAME <u>Annie Disney</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u>	
16. SOCIAL SECURITY No. <u>None</u>		17. INFORMANT AND ADDRESS <u>James Cox Owings Mills, Md.</u>	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Suffocation by compression</u>			<u>1/2 hr.</u>
Antecedent cause(s) (b) <u>of Export Tractor.</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>			
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION <u>None</u>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY <u>Farm</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>May 10 1951 8 P.m.</u>		HOW DID INJURY OCCUR? <u>upset tractor pinned her to ground.</u>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>D. D. Caples M.D.</u>		DATE SIGNED <u>5-12-51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>	
DATE REC'D BY LOCAL REG. <u>5-12-51</u>		24. FUNERAL DIRECTOR ADDRESS <u>J.F. Eline & Sons, Reisterstown, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 17 1961
BUREAU A. S.

MARYLAND STATE DEPARTMENT OF HEALTH

04581

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH COUNTY <u>Balto</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Mt Carmel</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Balto</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Mt Carmel</u> STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>WILSON - KERNEY - COX</u> (First) (Middle) (Last)		4. DATE OF DEATH <u>May 12</u> 19 <u>51</u> (Month) (Day) (Year)	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov 26 - 1874</u> 78 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Stone Mason</u>	
11. BIRTHPLACE (State or foreign country) <u>Ind</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Oliver Cox</u>		14. MOTHER'S MAIDEN NAME <u>Susan Wilhelm</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>✓</u>	
17. INFORMANT AND ADDRESS <u>Mrs Kerney Cox - Uppered Ind</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Coronary Thrombosis

INTERVAL BETWEEN ONSET AND DEATH

20 minutes

Antecedent cause(s)

(b) Hypertensive C.V. disease15 years

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c) Carcinoma of Prostate4 1/2 years

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Carcinoma of Prostate4 1/2 yrs

19a. DATE OF OPERATION <u>1947</u>		19b. MAJOR FINDINGS OF OPERATION <u>Ca of Prostate</u>		20. AUTOPSY? <u>Yes</u> <input type="checkbox"/> <u>No</u> <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, office bldg., etc.) <u>Ind</u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from June, 1941, to May 12, 1951, that I last saw the deceased alive on May 12, 1951, and that death occurred at 7:15 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE, SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>May 10/51</u>		NAME OF CEMETERY OR CREMATORY <u>Mt Carmel</u>		LOCATION (City, town, or county) <u>Balto Co. Ind</u>		(State)	
DATE REC'D BY LOCAL REG. <u>5-14-51</u>		REGISTRAR'S SIGNATURE <u>Mary B. Eline</u>		24. FUNERAL DIRECTOR <u>Edna Chipton</u>		ADDRESS <u>Hampstead</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

504246 Ind

REC-114-20
MAY 17 1961
BUREAU A. J.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04582

Reg. Dist. No. 20

1. PLACE OF DEATH COUNTY Baltimore, MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Md. COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Opitz Home		STREET ADDRESS (If rural give location) 1091 W. Fayette St.	
3. NAME OF DECEASED (Type or Print) Annie Louise Cromer		4. DATE OF DEATH (Month) May (Day) 15, (Year) 19 51	
5. SEX Female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed	8. DATE OF BIRTH June 20, 1874
9. AGE last birthday 76 yrs.		10. If under 1 year (Month) (Day) (Hour) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Berrysburg, Pa.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Calvin Lentz		14. MOTHER'S MAIDEN NAME Lydia Ann Wilbert	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No.	
17. INFORMANT Mr. Henry H. Lentz 3304 Clifton Ave.			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Cerebral Hemorrhage

INTERVAL BETWEEN ONSET AND DEATH

5 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

Hypertensive Cardio Vascular Disease

Unknown

(c)

General Arteriosclerosis

Unknown

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Bronchitis Pulmonia

3 days

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **5/10, 1951**, to **5/15, 1951**, that I last saw the deceased

alive on **5/15, 1951**, and that death occurred at **10:30 P.M.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Paul R. Ziegler M.D.

3723 Edmondson Ave

5/17/51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	May 19, 1951	Maple Grove Cemetery	Elizabethville, Pa.	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
5-17-51		John O. Mitchell	1900 Eutaw Place	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Ziegler
3723 E. Ave.
12.45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 04583

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Port Howard</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Vets. Adm. Hos. Ft. Howard, Md.</u>		STREET ADDRESS (If rural, give location) <u>608 N. Bethel St.</u>	
3. NAME OF DECEASED (Type or Print) <u>HUNTER ALSO JOHN H.</u>		4. DATE OF DEATH <u>5-22</u> 19 <u>51</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>separated</u>	8. DATE OF BIRTH <u>10-27-92</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	9. AGE last birthday <u>58</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>King & Queen Co. Va.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Daniel Davis</u>		14. MOTHER'S MAIDEN NAME <u>Jennie Randall</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes</u> <u>WW-1</u>		16. SOCIAL SECURITY No. <u>705-10-9132</u>	
17. INFORMANT AND ADDRESS <u>Clin. Rec. Vets. Adm. Hosp. Ft. Howard, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Myocardial failure

INTERVAL BETWEEN ONSET AND DEATH

unknown

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Hypertension

unknown

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that VA attended the deceased from May 21, 19 51, to May 22, 19 51, that last saw the deceased

live on and that death occurred at 7:40A m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

IRVING FREEMAN, MD. ACTING CHIEF, MEDICAL SERVICE VAH FT. HOWARD, MD.

5-24-51

23. BURIAL, CREMATION OR OTHER (Specify)	DATE HEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>5/28/51</u>	<u>Balto. National Cemetery</u>	<u>5501 Frderick Ave. Balto. Md.</u>	

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>5/25/51</u>	<u>[Signature]</u>	<u>Young Funeral Home</u>	<u>1532 E. Monument St.</u>

970506 Balto 5/28/51

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 35

04584

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>rural Parkton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>rural - Parkton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rayville</u>		STREET ADDRESS (If rural, give location) <u>Rayville</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>William</u>	(Middle) <u>Cooper</u>	(Last) <u>Dix</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	4. DATE OF DEATH Month <u>May</u> Day <u>5</u> Year <u>1951</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>	8. DATE OF BIRTH <u>May 7, 1871</u>
13. FATHER'S NAME <u>Tandy F. Dix</u>		11. BIRTHPLACE (State or foreign country) <u>Wythe Co., Va.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>--</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Nellie Dix, Parkton, Md. R.D.</u>		14. MOTHER'S MAIDEN NAME <u>Rhoda Catron</u>	
16. SOCIAL SECURITY NO. <u>--</u>		17. INFORMANT AND ADDRESS <u>Mrs. Nellie Dix, Parkton, Md. R.D.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Cerebral hemorrhage

INTERVAL BETWEEN ONSET AND DEATH

4 hrs.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Hypertension(c) Arterio-sclerosisII. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from....., 19..40., to...May.....5...., 1951., that I last saw the deceased

alive on.....May.....5...., 19..51., and that death occurred at...5:25...p./m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>May 9, 1951</u>	<u>New Bethel Meth. Cem.</u>	<u>Wythe Co., Va.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS		
<u>May 7, 1951</u>	<u>Chester L. Fulton</u>	<u>J. Jacob Hartenstein, New Freedom, Pa.</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

RECEIVED

1931

6 3

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04585

CERTIFICATE OF DEATH

Reg. Dist. No. 45

1. PLACE OF DEATH- COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Md. COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Harbor View		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Harbor View	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 7203 Woodrow Ave.		STREET ADDRESS (If rural give location) 7203 Woodrow Ave.	
3. NAME OF DECEASED (Type or Print)	(First) SOPHIA (Middle)	(Last) DORN	4. DATE OF DEATH (Month) May (Day) 25 (Year) 54
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH March 26, 1878
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY House Work.	9. AGE last birthday 75 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME ? Szymanski		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. No	
17. INFORMANT Julia Rodenberg 7203 Woodrow Ave			

18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Auricular Fibrillation Myocardial	10 days
Antecedent cause(s) (b) Broncho-pneumonia Failure	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Degenerative Arthritis	
Cerebral Thrombosis	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **5/15/51**, 19**51**, to **5/25/51**, 19**51**, that I last saw the deceased alive on **5/25/51**, 19**51**, and that death occurred at **5:00 P.m.**, from the causes and on the date stated above.

SIGNATURE **SAHLER** (Degree or title) ADDRESS **4613 Easton Av.** DATE SIGNED **5/27/51**

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF May 28 1951	NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery	LOCATION (City, town, or county) (State) 57420' Donnell St. Balto., Md.
DATE RECD BY LOCAL REG. 5/28/51	REGISTRAR'S SIGNATURE A. W. Hedrick	24. FUNERAL DIRECTOR Charles S. Feiler	ADDRESS 901 S. Conkling St. Balto.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

720836

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04586

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Balt.</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Port Howard</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore 21, Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Vet. Adm. Hosp., Ft. Howard, Md.</u>		STREET ADDRESS (If rural, give location) <u>13 Plateau Road</u>	
3. NAME OF DECEASED (First) <u>ALPHA</u> (Middle) <u>E.</u> (Last) <u>DRUMMOND</u>	4. DATE OF DEATH (Month) <u>May</u> (Day) <u>9</u> (Year) <u>19 51</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>12-31-89</u>
9. AGE last birthday <u>61</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer - Factory</u>	
11. BIRTHPLACE (State or foreign country) <u>Meadowbrook, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Steven A. Drummond</u>		14. MOTHER'S MAIDEN NAME <u>Bell Fortney</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO. <u>235-12-4090</u>	
17. INFORMANT AND ADDRESS <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) CORONARY ARTERIOSCLEROSIS WITH INFARCTION

UNKNOWN

Antecedent cause(s)

(b) NONE

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. NONE

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 4, 19 51, to May 9, 19 51, that I last saw the deceasedalive on May 4, 19 51, and that death occurred at 2:10 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

M. N. Jensen M.D.VAH, FORT HOWARD, MARYLAND5-9-51

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

5/10/51R. W. HedrickHoward Blight Funeral Home 6009 Harford Rd.Balto., Md.Michael J. Blight 970379

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 38

04587

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Stoneleigh</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Armocost Nursing Home</u>		STREET ADDRESS (If rural, give location) <u>5703 Chinquapin Parkway</u>	
3. NAME OF DECEASED (Type or Print) <u>Helen</u> (First) <u>Q.</u> (Middle) <u>Elliott</u> (Last)		4. DATE OF DEATH <u>May 30,</u> 19 <u>51</u> (Month) (Day) (Year)	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 2, 1888</u> 62 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ret. house mother</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N.Y. State Children's Aid</u>	
11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>Ida M. Williams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Mrs. Margaret E. Fis, 5703 Chinquapin</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Cerebral Hemorrhage

INTERVAL BETWEEN ONSET AND DEATH

19 Hrs

Antecedent cause(s)

(b)

Hypertensive Cardio-Renal

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

Vascular Disease3 yrs

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Not While Work ☐ At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/11, 19 51, to May 30, 19 51, that I last saw the deceasedalive on 5/29, 19 51, and that death occurred at 3:00 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

6/1/51A.W. BednerH.M. Cook, Inc.1217 St. Paul Street

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

764917

Dr. Arthur Karfgin MARYLAND STATE DEPARTMENT OF HEALTH
Northwood Apartments

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04588

Reg. Dist. No. 38

1. PLACE OF DEATH- COUNTY Towson MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Towson	
CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore		CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 501 West Chesapeake Ave.		STREET ADDRESS (If rural, give location) 501 West Chesapeake Avenue	
3. NAME OF DECEASED (Type or Print)	(First) Raymond (Middle) L (Last) Evans	4. DATE OF DEATH (Month) May (Day) 14th (Year) 1951	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Sept. 16, 1905
9. AGE last birthday 45 yrs.		10. If under 1 year Months 0 Days 0 If under 24 hrs. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY B.F. Goodrich Co	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Lewis R. Evans		14. MOTHER'S MAIDEN NAME Pearl M. Eckert	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 275-05-7413	
17. INFORMANT AND ADDRESS Mrs. Emma F. Evans, 501 W. Chesapeake			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause PARAPLEGIA - F			2 MONTHS
(b) Antecedent cause(s) 199.8 Disease or conditions, if any, giving rise to the above cause stating the underlying cause last 55b METASTATIC CARCINOMA TO SPINE AND INTERVERTEBRAL DISC.			8 MONTHS
(c) ORIGINAL SITE UNDETERMINED.			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION 1-20-51		19b. MAJOR FINDINGS OF OPERATION 4 LUMBAR INTERVERTEBRAL DISC	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) NONE		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from OCT. 50 , 19 50 , to MAY 14 , 19 51 , that I last saw the deceased alive on MAY 13 , 19 51 , and that death occurred at 10:55 A.M. , from the causes and on the date stated above.			
SIGNATURE Arthur Karfgin M.D.		ADDRESS 4230 Loch Raven Blvd.	
DATE SIGNED 5/14/51			
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF 5/17/51	
NAME OF CEMETERY OR CREMATORY Northwood Cemetery		LOCATION (City, town, or county) Baltimore, Md.	
DATE REC'D BY LOCAL REG. 5/16/51		24. FUNERAL DIRECTOR Leonard J. Ruck, 5305 Harford Road.	

490-667

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural: Towson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eudowood Sanatorium</u> <u>Towson 4, Maryland</u>		STREET ADDRESS (If rural, give location) <u>528 N. Payson St.</u>	
3. NAME OF DECEASED (Type or Print) <u>William Emory EVANS</u>		4. DATE OF DEATH (Month) <u>MAY</u> (Day) <u>30</u> (Year) <u>1951</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Dec. 31, 1885</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Molder (STEEL)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wash. Navy Yard</u>	9. AGE last birthday <u>65</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>	
13. FATHER'S NAME <u>George EVANS</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE MURR</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Personal History- Hospital Records, Eudowood Sanatorium</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Pulmonary Tuberculosis

INTERVAL BETWEEN ONSET AND DEATH

8 yr

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 14, 1946, to May 30, 1951, that I last saw the deceased alive on May 29, 1951, and that death occurred at 1:30 p.m. from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

5/31/51Wm. A. BridgesW.D., Eudowood Sanatorium, Towson 4, MarylandJune 2/51RandonBalto. Md.Harry H. Witzke4101 Edmondson Ave

690 378

04590
~~Better~~ Deary 41

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF STILLBIRTH

Reg. Dist. No.

A certificate must be filed within 24 hours for every stillbirth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:

County Baltimore
City or town DUNDALK - MD
(If outside city or town limits, write RURAL and give nearest town)
Street address, hospital, or institution:
3327 McShaneway
Length of mother's stay in County 4 yrs.
(How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:

State Maryland
County Baltimore
City or town Dundalk - MD
(If outside city or town limits, write RURAL and give nearest town)
Street No. 8114 Bull Neck Road
(If RURAL give LOCATION)

3. Name of child

Baby Girl Falecki

5. Sex

Female

6. Twin or triplet

—

4. Date of birth

May 11 1951 Hour 6:30 A.M.

7. No. of weeks pregnancy

24 weeks

FATHER OF CHILD

8. Full name

Francis J. Falecki

9. Color

White

10. Age at time of this birth

27 yrs.

11. Usual occupation

Fremont, Penn Md. Co.

MOTHER OF CHILD

12. Full maiden name

JOAN Kemp

13. Color

Wh.

14. Age at time of this birth

20 yrs.

15. Usual occupation

Housewife

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 0

(b) How many other children were born alive but are now dead? 0 (c) How many other children were born dead? 0

17. Did child die before labor? no

During labor? no

18. Pregnancy, complications of

none

19. Labor: (a) Complications of

none

(b) Induced? no

20. (a) Was there an operation for delivery? no

(Yes or No)

(b) State all operations, if any

none

(c) Did child die before operation? no

During operation? no

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.

(a) Fetal causes

Prematurity

(b) Maternal causes

22. I certify to the birth of this child who was born dead on the date and hour above stated.

Signature

(Specify if M. D., midwife, or other)

Address

Dundalk - MD

23. (a) BURIAL (Burial, cremation or removal)

(b) Date thereof 5-12-51
(month) (day) (year)

(c) Cemetery or crematory

OAK LAWN

24. (a) Funeral director

Walter Brooks Bradley

(b) Address

Dundalk MD

25. (a) May 11-1951 (Date rec'd by registrar)

(b) William M. Kelly (Registrar)

26. (To be filled out if no physician was present at delivery.)
The above certificate has been examined by me.

Health Officer, per

* See Instruction C on stub.

10511120124V

Child Lived 10 minutes

V. S. A10

RECEIVED
MAY 14 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 38

04591

1. PLACE OF DEATH - COUNTY <u>Towson</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Loch Raven</u>		STREET ADDRESS (If rural, give location) <u>1651 E Cold Spring Lane</u>	
3. NAME OF DECEASED (First) <u>Joseph</u>	(Middle) <u>Anthony</u>	(Last) <u>Farrell JR.</u>	4. DATE OF DEATH (Month) <u>May</u> (Day) <u>30</u> (Year) <u>1951</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>April 19-1937</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>14</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Joseph Farrell Sr</u>		14. MOTHER'S MAIDEN NAME <u>Mary Catherine Reynolds</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
		17. INFORMANT <u>Mr. Joseph A. Farrell - same</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

929.8 Immediate cause (a) Drowned
 Antecedent cause(s) (b) 183
 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
 Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>5-30-51</u> m.	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>Drowning</u>		

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>6-3-51</u>	NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>	LOCATION (City, town, or county) <u>Baltimore Md</u>	(State)
DATE REC'D BY LOCAL REG. <u>6-1-51</u>	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR <u>L. Luck</u>	ADDRESS <u>5305 Hayford Rd</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

04592

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington D. C.</u>	
TOWN <u>Catonsville</u> LENGTH OF STAY (in this place) <u>8 yrs., 10 mths., 9 days</u>		TOWN <u>Washington D. C.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>		STREET ADDRESS (If rural, give location) <u>708 "A" Street, N.E.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>ARDELLA</u> (Middle) <u>V.</u> (Last) <u>FISSELL</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>29</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Dec. 17, 1869</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>domestic</u>	9. AGE last birthday <u>81</u> yrs. <u>5</u> Months <u>12</u> Days <u>12</u> Hours <u>12</u> Min.
11. BIRTHPLACE (State or foreign country) <u>Howard County, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Robey Easton</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth (maiden name unknown)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Hospital Records, Catonsville 28, Md.</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Carcinoma of the/breast with axillary metastasis</u>		<u>right</u>	<u>over 9 yrs.</u>
Antecedent cause(s) (b) <u>Chronic myocarditis</u>			<u>Several yrs</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Generalized arteriosclerosis</u>			<u>" "</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>		INJURY OCCURRED While at <input type="checkbox"/> Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from July 1, 1950, to May 29, 1951, that I last saw the deceased alive on May 29, 1951, and that death occurred at 8:25 a.m., from the causes and on the date stated above.

SIGNATURE John P. Risley M.D. (Degree or title) ADDRESS Spring Grove State Hospital DATE SIGNED 5-29-51
Catonsville 28, Md.

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>June 1, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Good Shepherd Cemetery</u>	LOCATION (City, town, or county) <u>Ellicott City, Maryland</u>	(State)
DATE REC'D BY LOCAL REG. <u>5/31/51</u>		REGISTRAR'S SIGNATURE <u>V. E. Harry</u>		24. FUNERAL DIRECTOR <u>Easton Sons, Catonsville, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 4 1961
BUREAU W. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04593

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Balto</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Gump Mills</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Gump Mills</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Garrison Rd</u>		STREET ADDRESS (If rural, give location) <u>Garrison Rd.</u>	
3. NAME OF DECEASED (Type or Print) <u>Robert Demison Frick</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>25</u> (Year) <u>1951</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE MARRIED, WIDOWED , DIVORCED (Specify)	8. DATE OF BIRTH <u>July 10, 1890</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Banker</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>61</u> yrs. If under 1 year: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
13. FATHER'S NAME <u>Charles Frick</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no) (If yes, give war or dates of service) <u>WWI</u>		14. MOTHER'S MAIDEN NAME <u>Mary Carroll Demison</u>	
16. SOCIAL SECURITY No.		17. INFORMANT <u>Mrs. Robt Demison Frick</u> <u>Same</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause <u>arterio-sclerosis not hypertensive</u>	(a) <u>8 mos.</u>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u> </u>	
(c) <u> </u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 38, 1938, to May 25, 1951, that I last saw the deceased alive on May 25, 1951, and that death occurred at 3 P. m., from the causes and on the date stated above.

SIGNATURE Robert D. Williams (Degree or title) M.D. ADDRESS Pikesville 8 Md. DATE SIGNED May 26, 1951

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE THEREOF May 28, 1951 NAME OF CEMETERY OR CREMATORY Green Mount LOCATION (City, town, or county) (State) Balto. Md.

DATE REC'D BY LOCAL REG. May 26, 1951 REGISTRAR'S SIGNATURE R. W. 24. FUNERAL DIRECTOR Henry W. Jenkins & Sons 4905 York Rd ADDRESS 2907 N

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04594

Reg. Dist. No. 38

1. PLACE OF DEATH COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Balto.	
CITY (If outside corporate limits, write RURAL and give nearest town) Carney		CITY (If outside corporate limits, write RURAL and give nearest town) Carney	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 2 W. Summit Ave.		STREET ADDRESS (If rural, give location) 2 W. Summit Ave	
3. NAME OF DECEASED (Type or Print)	(First) Nellie	(Middle) E.	(Last) Gambrill
4. DATE OF DEATH	(Month) May	(Day) 15	(Year) 1951
5. SEX F.	6. COLOR OR RACE W.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH August 8, 1873
9. AGE last birthday 77 yrs.	If under 1 year Months 77	If under 24 hrs. Days 77	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home
11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Edwin Dulaney	14. MOTHER'S MAIDEN NAME Treasa Kimmel
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY No. (If yes, give war or dates of service)	17. INFORMANT Wn. G. Gambrill	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause	(a) High Blood Pressure	2 yr
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hardening of Arteries	3 yr
	(c) Paralysis	2 day
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY May 14 1951	INJURY OCCURRED White at Work <input type="checkbox"/> Not White At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Jan 3, 1951**, to **May 15 1951**, that I last saw the deceased alive on **5/14/1951**, and that death occurred at **7 P.M.**, from the causes and on the date stated above.

SIGNATURE **D. R. C. Hearn** (Degree or title) ADDRESS **3901 Garrison Blvd** DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF May 17, 1951	NAME OF CEMETERY OR CREMATORY Moreland Memorial	LOCATION (City, town, or county) Baltimore Md.	(State)
DATE REC'D BY LOCAL REG. 5/16/51	REGISTRAR'S SIGNATURE G. M. Bacon	24. FUNERAL DIRECTOR EVANS FUNERAL Home	ADDRESS 8802 Hanford Rd.	

Pr JAC S. EVANS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

Dr. Arthur C. Hearn
3901 Garrison Blvd.

RECEIVED
MAY 18 1951
BUREAU A. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore.

CERTIFICATE OF DEATH

Reg. Dist. No. 31

04595

1. PLACE OF DEATH- COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>BALTIMORE</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>COCKEYSVILLE (RURAL)</u>	
TOWN <u>Cockeysville</u>		TOWN <u>COCKEYSVILLE (RURAL)</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>CUBA ROAD (RURAL)</u>		STREET ADDRESS <u>CUBA ROAD</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>EDWARD</u> <u>STEPHEN</u> <u>GANNON</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>MAY</u> <u>9</u> <u>1951</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWER</u>	8. DATE OF BIRTH <u>DEC. 26, 1970</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED - BOLLER MAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B.T.O. R.R.</u>	9. AGE last birthday <u>80</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>IRELAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY No. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>MRS. J. SHOWELL, COCKEYSVILLE, MD.</u>			

13. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Myocardial Infarction

Antecedent cause(s)

(b)

Atherosclerosis - Myocarditis

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office hldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
HOMICIDE INJURYTIME (Month) (Day) (Year) (Hour) OF INJURY m. INJURY OCCURRED While at Work ☐ Not While at Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 15, 1951, to May 9, 1951, that I last saw the deceasedalive on May 8, 1951, and that death occurred at 4:30 P. m., from the causes and on the date stated above.

SIGNATURE

John E. Scheurich M.D.

ADDRESS

1337 S. Charles St. Baltimore 5/10/5123. BURIAL CREMATION REMOVAL (Specify) DATE NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)
BURIAL MAY 12, 1951 HOLY REDEEMER CEM. BALTIMORE, MD.

DATE REC'D BY LOCAL REG.

5/11/51

REGISTRAR'S SIGNATURE

W. Hedrick

24. FUNERAL DIRECTOR

JOHN BURNS' SONS, TOWSON, MD.

ADDRESS

JOHN BURNS' SONS, TOWSON, MD.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

503506

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04596

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> <u>Baltimore</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Glyndon</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Glyndon</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Butler Road</u>		STREET ADDRESS (If rural, give location) <u>Butler Road</u>	
3. NAME OF DECEASED (Type or Print) <u>Reuben Paul Geist</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>6</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 9, 1869</u>
9. AGE last birthday <u>82 yrs.</u>		10. If under 1 year Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cwner</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Jacob D. Geist</u>		14. MOTHER'S MAIDEN NAME <u>Susanna Trout</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT <u>Elam Geist, Glyndon, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Coronary artery disease

INTERVAL BETWEEN ONSET AND DEATH

1 wks.

Antecedent cause(s)

(b)

Generalized arteriosclerosis5 yrs.

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.None.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

None.

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE	(Specify) <u>No.</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	<u>None.</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	<u>None</u> m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	<u>None.</u>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 4-19, 1937, to May 6, 1951, that I last saw the deceased alive on May 6, 1951, and that death occurred at 7:30 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

D.D. CaplesM.D. Reisterstown, Md.5-7-51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>May 9, 1951</u>	<u>Geist Meeting House</u>	<u>Baltimore Co.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>5-8-51</u>	<u>Mary B. Eline</u>	<u>J.F. Eline & Sons</u>	<u>Reisterstown, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 17 1961
BUREAU A. J.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

04597

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u> <u>Catonsville, Md.</u>		STREET ADDRESS (If rural, give location) <u>3209 Leighton Avenue</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Meyer</u>	(Middle)	(Last) <u>Glaser</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>July 4, 1902</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	9. AGE last birthday <u>48</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Adolph Glaser</u>		14. MOTHER'S MAIDEN NAME <u>Frieda Ziskin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No.	
(If year, give war or dates of service)		17. INFORMANT AND ADDRESS <u>Reuben Glaser- 3601 Labyrinth Road</u>	

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>Cerebral hemorrhage</u>			<u>11 days</u>
Antecedent cause(s) (b) <u>Generalized arteriosclerosis</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Psychosis with mental depression</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Nov</u> , 19 <u>50</u> , to <u>May 27</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>May 27</u> , 19 <u>51</u> , and that death occurred at <u>5</u> <u>10</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Samuel C Gordon, M.D.</u>		ADDRESS <u>Spring Grove Hospital</u> DATE SIGNED <u>5.27.51</u>	
23. BURIAL, CREMATION REMOVAL (Specify)	DATE <u>5/28/51</u>	NAME OF CEMETERY OR CREMATORY <u>Anshei Nessin Cong.</u>	LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
DATE REC'D BY LOCAL REG. <u>5/28/51</u>	REGISTRAR'S SIGNATURE <u>a d Hedrick</u>	FUNERAL DIRECTOR <u>Sol. Linsion + Bros. - 124-26 W. North Avenue</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

04598

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Ma.</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>606 North Bend Road.</u>		STREET ADDRESS (If rural, give location) <u>606 North Bend Road</u>	
3. NAME OF DECEASED (Type or Print) <u>LeRoy</u> (First) <u>C.</u> (Middle) <u>Gorsuch</u> (Last)		4. DATE OF DEATH <u>May 2/51</u> (Month) (Day) (Year) 19	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH <u>about 1900</u>
9. AGE last birthday <u>52</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief Clerk</u>	
11. BIRTHPLACE (State or foreign country) <u>Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Gorsuch</u>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Mrs. Bertha Gorsuch, 606 North Bend Rd</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Coronary Thrombosis

INTERVAL BETWEEN ONSET AND DEATH

1/2 hr.

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from May 2, 1951, to May 2, 1951, that I last saw the deceased alive on May 2, 1951, and that death occurred at 8:30 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE/SIGNED

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE TIME OF <u>May 7/51</u>	NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	LOCATION (City, town, or county) <u>5501 Frederick Rd. Baltimore</u>
DATE REC'D BY LOCAL REG. <u>5/7/51</u>	REGISTRAR'S SIGNATURE <u>V.E. Harry</u>	24. FUNERAL DIRECTOR <u>Harry H. Witzke</u>	ADDRESS <u>101 Edmondson Ave.</u>

390377

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAY 9 1967
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04599

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Md. COUNTY Balto.	
CITY (If outside corporate limits, write RURAL and give nearest town) Catonsville		CITY (If outside corporate limits, write RURAL and give nearest town) Catonsville	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 56 Wade Ave.		STREET ADDRESS (If rural, give location) 56 Wade Ave.	
3. NAME OF DECEASED (First) Elizabeth (Middle) P. (Last) Graham		4. DATE OF DEATH (Month) May (Day) 11 (Year) 1951	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Aug. 31, 1885
9. AGE last birthday 65 yrs.		10. If under 1 year Months 11 Days 19 If under 24 hrs. Hours 19 Mln.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? Maryland	
13. FATHER'S NAME Charles Mumford		14. MOTHER'S MAIDEN NAME Ellen Godfrey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. B. Compton Graham, 56 Wade Ave. Catonsville, Md.	
17. INFORMANT AND ADDRESS B. Compton Graham, 56 Wade Ave. Catonsville, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) **Coronary artery disease**

INTERVAL BETWEEN ONSET AND DEATH

3 yrs

Antecedent cause(s)

(b) **Hypertensive Cardiovascular disease**

(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify) —	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from..... 1935, to **May 11, 1951**, that I last saw the deceased

alive on **May 11, 1951**, and that death occurred at **8 PM** m., from the causes and on the date stated above.

SIGNATURE **Robert B. Taylor** (Degree or title) ADDRESS **104 W. Madison St.** DATE SIGNED **May 12-51**

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF May 14/51	NAME OF CEMETERY OR CREMATORY Lorraine Pk.	LOCATION (City, town, or county) (State) Woodlawn, Md.
DATE REC'D BY LOCAL REG. May 12 1951	REGISTRAR'S SIGNATURE R. W.	24. FUNERAL DIRECTOR Harry A. Hutzler	ADDRESS 4101 Edmondson Ave

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04600

Reg. Dist. No. 41

1. PLACE OF DEATH:

County... Baltimore
 City or town... Baltimore City
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md. County... Balto.
 City or town... Baltimore City
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 41 Waterview Rd
 (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME

Bertha Matilda Grape

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widow6.(b) Name of husband or wife John M. Grape

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 12-1960

8. AGE:

Years

Months

Days

If less than one day

9131

hrs. min.

9. Birthplace:

Balto. Md.

(Town, county, and state)

10. Usual occupation:

Housework

11. Industry or business

FATHER

12. Name

John Woodfield

13. Birthplace

Md.

MOTHER

14. Maiden name

Alice Hickman

15. Birthplace

Md.

16. Informant

Emma Schultz

Address

41 Waterview Rd. Balto. Co.

17.

(Burial, cremation, or removal, Which?)

Date thereof

May 15-51

Cemetery or crematory

Trinity Cem.

Location

O'Donnell St.

18. Funeral director

John A. Miller

Address

2334 Jefferson St.

19.

(Date rec'd by registrar)

5/15A. W. Hedrick

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1951 at 5:00 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 15 1951 to May 13 1951and that I last saw her alive on May 13 1951

Immediate cause of death

Arteriosclerotic Heart Disease
Uremia

DURATION

10 yrs1 wk.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

James T. Means M.D.

M. D. or other

Address

520 N. St.Date signed 5/14/51

8027.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 42

04601

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 17</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Vet. Adm. Hosp., Ft. Howard, Md.</u>		STREET ADDRESS (If rural, give location) <u>1645 North Appleton Street</u>	
3. NAME OF DECEASED (First) <u>HENRY</u> (Middle) <u>ROBERTSON</u> (Last) <u>GREEN</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>8</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>6-24-20</u>
9. AGE last birthday <u>30</u> yrs.		10. If under 1 year: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Watchmaking Student</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>South Boston, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Green</u>		14. MOTHER'S MAIDEN NAME <u>Lou Gollum</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>226-32-9407</u>	
17. INFORMANT AND ADDRESS <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) MILIARY TUBERCULOSIS

Antecedent cause(s)

(b) NONE

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

NONE

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) SUICIDE PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

TIME (Month) (Day) (Year) (Hour) OF INJURY m. INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that VA attended the deceased from March 16, 1951, to May 8, 1951.

and that death occurred at 8:15 A. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

M. N. Jensen M.D.

VAH, FORT HOWARD, MARYLAND

5-9-51

23. BURIAL, CREMATION, REMOVAL (Specify) Removal DATE THEREOF NAME OF CEMETERY OR CREMATORY Pine Grove Cemetery LOCATION (City, town, or county) South Boston, Virginia (State)

DATE REC'D BY LOCAL REG. 5/10/51

REGISTRAR'S SIGNATURE W. Hedrick

24. FUNERAL DIRECTOR

ADDRESS

Charles R. Law 802 Madison Avenue

SHIP TO: Otis Gerst Funeral Home
South Boston, Virginia

Baltimore, Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. **30**

1. PLACE OF DEATH- COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) Catonsville		CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Spring Grove State Hospital		STREET ADDRESS (If rural, give location) 1427 N. Charles Street	
3. NAME OF DECEASED (First) FRANK (Middle) H. (Last) GRIMM		4. DATE OF DEATH (Month) May (Day) 12 (Year) 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH March 15, 1883
9. AGE last birthday 68 yrs.		10. If under 1 year Months 1 Days 27 If under 24 hrs. Hours 27 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Cab Driver		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME William Grimm		14. MOTHER'S MAIDEN NAME Kate (maiden name unknown)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS Hospital Records, Catonsville 28, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) **Arteriosclerotic heart disease**

INTERVAL BETWEEN ONSET AND DEATH

Over 4 yrs.

Antecedent cause(s)

(b) **Arteriosclerotic nephrosclerosis**

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c) **Arteriosclerosis, generalized**

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Mar. 24, 1951**, to **May 12, 1951**, that I last saw the deceased

alive on **May 12, 1951**, and that death occurred at **4:50 p.m.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Ethel B. Hermann Green M.D.

Spring Grove State Hospital

5-14-51

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

5-16-51

Wm. Cook, Inc. 1217 St. Paul Street

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

692536

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04603

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore Pikesville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore Pikesville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7401 Brightside Avenue</u>		STREET ADDRESS (If rural, give location) <u>7401 Brightside Avenue</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Charles</u>	(Middle) <u>Francis</u>	(Last) <u>Groves</u>
4. DATE OF DEATH	(Month) <u>May</u>	(Day) <u>18</u>	(Year) <u>1951</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Aug. 19, 1879</u>
9. AGE last birthday <u>71</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Groves</u>		14. MOTHER'S MAIDEN NAME <u>Laura Bowersox</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>216-07-8859 A</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Mary R. Groves, 7401 Brightside</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Cardiac Fibrosis

over year

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) 93d

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. X

19a. DATE OF OPERATION X

19b. MAJOR FINDINGS OF OPERATION X

20. AUTOPSY? X

21. ACCIDENT SUICIDE HOMICIDE

(Specify) X

PLACE (Home, farm, factory, street, OF office bldg., etc.) X

(CITY OR TOWN) X

(COUNTY)

(STATE) X

TIME (Month) (Day) (Year) (Hour) OF INJURY X

INJURY OCCURRED While at Work X Not White At work X

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 6, 1950 to May 18, 1951, that I last saw the deceased

alive on May 17, 1951, and that death occurred at 5:45 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Allen S. Beetham M.D.

3139 E. Baugh

May 21-51

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF 5-22-51

NAME OF CEMETERY OR CREMATORY Moreland Mem. Park

LOCATION (City, town, or county) Baltimore, Md.

(State)

DATE REC'D BY LOCAL REG. 5/21/51

REGISTRAR'S SIGNATURE A.W. Hedrick

24. FUNERAL DIRECTOR

ADDRESS

Leonard J. Ruck, 5305 Harford Road.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

523 337

Item 9 on: **Form No. G 1 MAY 22 1951**

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04604

Reg. Dist. No. **37**

1. PLACE OF DEATH: COUNTY Baltimore CITY (If outside corporate limits, write RURAL and give nearest town) Texas TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS Baltimore County Home		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Baltimore CITY (If outside corporate limits, write RURAL and give nearest town) Parkville TOWN STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) Alfred (Middle) - (Last) Halvorson		4. DATE OF DEATH (Month) May (Day) 15 (Year) 1951	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH unknown
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter		10b. KIND OF BUSINESS OR INDUSTRY laborer	11. BIRTHPLACE (State or foreign country) Sweden
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		17. INFORMANT AND ADDRESS Mrs. Jennie Halvorson 1825 W. Lombard St. Baltimore, Md.	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) **Anterior chest heart disease**

Antecedent cause(s)

(b) **Hypertension**

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c) **Generalized arteriosclerosis**

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN ONSET AND DEATH

years.

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **Jan 1, 1951**, to **May 15, 1951**, that I last saw the deceased alive on **May 7, 1951**, and that death occurred at **6 a.m.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	May 16/51	Mt. Carmel	Baltimore City	Md.
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
5/15/51	Wm J Chilcoat	Leonard J Buck	Baltimore	

5305 Handford Rd.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
1961 OCT 10
1961 OCT 10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. **XX**

1. PLACE OF DEATH- COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Fort Howard		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN 3000 Reisterstown Road	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hosp.		STREET ADDRESS (If rural, give location) Apt. A-1B	
3. NAME OF DECEASED (First) MICHAEL (Middle) M. (Last) HARRIS		4. DATE OF DEATH (Month) May (Day) 26 (Year) 19 51	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 9-15-94
9. AGE last birthday 56 yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY unknown?	
11. BIRTHPLACE (State or foreign country) New York, New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Morris Harris		14. MOTHER'S MAIDEN NAME Rachel Kouchman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war, or dates of service) Yes WW I		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT AND ADDRESS Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) MESENTERIC THROMBOSIS (SMALL INTESTINE)			UNKNOWN
Antecedent cause(s) (b) 570.2 Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) 99			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from May 22 , 19 51 , to May 26 , 19 51 , and that death occurred at 10:00 A.M. , from the causes and on the date stated above.			
SIGNATURE P. C. Newnam, M.D.		ADDRESS VAH, FORT HOWARD, MARYLAND	
DATE SIGNED 5-26-51			
23. BURIAL CREMATION REMOVAL (Specify) Burial		DATE THEREOF 5/29/51	
NAME OF CEMETERY OR CREMATORY Baltimore National		LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Howard Blight Funeral Home		ADDRESS 6009 Harford Rd., Baltimore, Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

04606

Reg. Dist. No. 31

1. PLACE OF DEATH- COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>HOWARD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Waldman</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>ELKridge</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rolling Rd & Belmount</u>		STREET ADDRESS (If rural, give location) <u>5418 MAIN ST.</u>	
3. NAME OF DECEASED (Type or Print) <u>WALTER</u> (First) <u>K. HARRIS</u> (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year) <u>5-1-1951</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>11/12/1892</u> 58 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Jobbing</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN F. HARRIS</u>		14. MOTHER'S MAIDEN NAME <u>ELLEN R.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>World War #1</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>216-09-8652</u>	
17. INFORMANT <u>CHARLES BONAL-ELKridge, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>Gun shot wound in head</u>			
Antecedent cause(s) (b) <u>Left temple 22 Rifle</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>suicide</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street or office bldg., etc.) <u>Street</u> (CITY OR TOWN) <u>Waldman</u> (COUNTY) <u>Balts</u> (STATE) <u>Md</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>May 1, 51 5-30 p.m.</u>		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> HOW DID INJURY OCCUR? <u>Gun shot wound in left side head</u>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input type="checkbox"/> suicide <input checked="" type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .			
SIGNATURE <u>Dr. Frank H. Newell</u> (Degree or title)		ADDRESS <u>1010 Leeds an</u> DATE SIGNED <u>May 3, 51</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>5/5/51</u> NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NATIONAL</u> LOCATION (City, town, or county) (State) <u>PIKESVILLE, MARYLAND</u>	
DATE REC'D BY LOCAL REG. <u>5/3/51</u>		REGISTRAR'S SIGNATURE <u>A.W. Pederson</u> 24. FUNERAL DIRECTOR <u>Frank H. Newell</u> ADDRESS <u>Pikesville, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

04607

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD.</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>House In Pines 16 Rusting ve.</u>		STREET ADDRESS (If rural, give location) <u>2000 Hollins St.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Louise M. H.</u> (Middle) <u>Heller</u> (Last) <u>(Henning)</u>	4. DATE OF DEATH (Month) <u>May</u> (Day) <u>12</u> (Year) <u>51</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Single</u>	8. DATE OF BIRTH <u>May 15, 1876</u>
9. AGE last birthday <u>74</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u></u>	
13. FATHER'S NAME <u>John R/ Heller</u>		14. MOTHER'S MAIDEN NAME <u>Emelia C.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY No. <u></u>	
17. INFORMANT AND ADDRESS <u>Dr. Emil H. Henning, 601 Winans Way</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) Cerebral vascular accident probably Thrombosis

3 weeks

Antecedent cause(s)

(b) Arteriosclerotic cardio-vascular disease

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from March 8, 1944, to May 12, 1951, that I last saw the deceased

alive on May 12, 1951, and that death occurred at 11:30 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Scam A. Kempf M.D.

3030 Edmondson Avenue

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>May 15/51</u>	<u>Loudon Pk., 3801 Frederick Rd.</u>	<u>Balto. 29</u>	<u>Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	4. FUNERAL DIRECTOR	ADDRESS	
<u>5/15/51</u>	<u>R. W. Hedrick</u>	<u>Harry A. Hutzler</u>	<u>1101 Edmondson Ave.</u>	

ST

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

Dr. Janney
7101 Harford

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04608

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH- COUNTY <u>Parkville</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Parkville</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2609 Hillcrest Avenue</u>		STREET ADDRESS (If rural, give location) <u>2609 Hillcrest Avenue</u>	
3. NAME OF DECEASED (Type or Print) <u>Barbara</u> (First) <u>Hilpert</u> (Middle) (Last)		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>31st</u> (Year) <u>1951</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Nov. 27, 1873</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>77</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Martin Sauers</u>		14. MOTHER'S MAIDEN NAME <u>???</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Mrs. Louise Johnson, 2609 Hillcrest</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>?</u>
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Coronary Heart Disease</u>		
Antecedent cause(s) (b) <u>Hypertensive B.V. Disease</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Arteriosclerosis</u>		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u> <u>HOMICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr. 1951, to May 31, 1951, that I last saw the deceased alive on May 31, 1951, and that death occurred at 11:00 P.m., from the causes and on the date stated above.

SIGNATURE Notker Janney M.D. ADDRESS 7101 Harford Rd. DATE SIGNED 6/1/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>6-4-51</u>	NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>	LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
DATE REC'D BY LOCAL REG. <u>6/8/51</u>	REGISTRAR'S SIGNATURE <u>W. H. Hedrick</u>	24. FUNERAL DIRECTOR <u>Leonard J. Ruck</u>	ADDRESS <u>5305 Harford Road.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04609

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Middle River</u> LENGTH OF STAY (in this place) <u>1 1/2</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Stemmers Run</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>ivy Hall Nursing Home</u>		STREET ADDRESS (If rural, give location) <u>8384 Old Phila. Rd.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Louis</u> (Middle) <u>A.</u> (Last) <u>Hoffmeister</u>	4. DATE OF DEATH	(Month) <u>5</u> (Day) <u>24</u> (Year) <u>1957</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>2/20/70</u>
9. AGE last birthday <u>81</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Watchman</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Barrel factory</u>	11. BIRTHPLACE (State or foreign country) <u>Balto. Co. Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	13. FATHER'S NAME <u>Albert Hoffmeister</u>	14. MOTHER'S MAIDEN NAME <u>Margaret E. Gable</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>217-26-4410</u>	17. INFORMANT AND ADDRESS <u>Mrs. J. G. Berk 8384 Old Phila. Rd.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Lower nephron nephrosis

INTERVAL BETWEEN ONSET AND DEATH

4 weeks

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arteriosclerotic renal disease

8 years

(c) Arteriosclerotic heart disease

8 years

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Generalized arteriosclerosis

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 20, 1949, to May 24, 1951, that I last saw the deceased

alive on May 23, 1951, and that death occurred at 6 A.M., from the causes and on the date stated above.

SIGNATURE Harvey L. Fuller MD

ADDRESS Ridge Rd Baltimore 6 DATE SIGNED May 24/51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>5-27-51</u>	<u>Union Mt. Cemetery</u>	<u>Balto. Co. Md.</u>	
DATE RECD BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>5/25/51</u>	<u>Dr. H. H. H. H.</u>	<u>Lorraine Funeral Home</u>	<u>4401 Blair Rd</u>	

VS. 15

763308

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

BIRTH NO.				CERTIFICATE OF DEATH		Registered No. 30	
1. NAME OF DECEASED (Type or Print) <i>Grace Hubbard</i>				2. DATE OF DEATH <i>May 11, 1951</i>			
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Baltimore</i>				4. USUAL RESIDENCE (Where deceased lived, if in institution; residence before admission) A. STATE <i>MD</i>			
B. FULL NAME OF (If not in hospital or institution, give street address or location) <i>Opety Nursing Home</i>				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>			
C. Length of stay in Baltimore <i>50 yrs</i>				D. STREET ADDRESS (If rural, give location) <i>1949 W. Mulberry St</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widow</i>	8. DATE OF BIRTH <i>Aug 18, 1860</i>		9. AGE (In years, last birthday) Months Days Hours Min. <i>91</i>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William H. Goette</i>				14. MOTHER'S MAIDEN NAME <i>Mary Emma Patchett</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>no</i>		17. INFORMANT ADDRESS <i>Ever W. H. 2503 Edmondson Ave</i>			
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO <i>arteriosclerotic heart disease</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>420.0 93d</i> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DUE TO <i>Generalized arteriosclerosis</i> (C) _____				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>3-10-48</i> , 19__, to <i>5-11-51</i> , 19__, that I last saw the deceased alive on <i>4-23-51</i> and that death occurred at _____ m., from the causes and on the date stated above.							
23A. SIGNATURE <i>Ray S. Lumbel</i>		23B. ADDRESS <i>2703 Edmondson</i>		23C. DATE SIGNED <i>5-14-51</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5-15-51</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Cambridge</i>		24D. LOCATION (City, town, or county) (State) <i>Cambridge, Md</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>5/14/51</i>		REGISTRAR'S SIGNATURE <i>A W Hedrick</i>		25. FUNERAL DIRECTOR ADDRESS <i>Howard H. Hubbard 2503 Edmondson Ave</i>			

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 04611

1. PLACE OF DEATH COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Fort Howard		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hosp.		STREET ADDRESS (If rural, give location) 1701 E. Baltimore Street	
3. NAME OF DECEASED (Type or Print)	(First) RALPH (Middle) (NMI) (Last) IRICK	4. DATE OF DEATH (Month) May (Day) 4 (Year) 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 3-20-93
9. AGE last birthday 58 yrs.		10. BIRTHPLACE (State or foreign country) Kentucky	
11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Irick		14. MOTHER'S MAIDEN NAME Pocohontas Ray	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give year or dates of service) WW I		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT AND ADDRESS Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		UNKNOWN
(a) Immediate cause CARCINOMA, LEFT ADRENAL		
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last None		
(c) Other significant conditions Conditions contributing to the death but not related to the disease or condition causing death. None		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE TIME (Month) (Day) (Year) (Hour) OF INJURY	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **April 16, 1951**, to **May 4, 1951**, and that death occurred at **10:00 A.M.**, from the causes and on the date stated above.

SIGNATURE **Clyde Cope, M.D.** (Degree or title) ADDRESS **VAH, FORT HOWARD, MARYLAND** DATE SIGNED **5-4-51**

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 5/8/51	NAME OF CEMETERY OR CREMATORY Baltimore National	LOCATION (City, town, or county) (State) Baltimore, Maryland
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DATE REC'D BY LOCAL REG 5/2/51	REGISTRAR'S SIGNATURE Dr. Medred Blight	24. FUNERAL DIRECTOR Howard Blight Funeral Home	ADDRESS 6009 Harford Road, Baltimore, Maryland
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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *4X*

04612

1. PLACE OF DEATH- COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) Fort Howard		CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hosp.		STREET ADDRESS (If rural, give location) 1312 Upton Street	
3. NAME OF DECEASED (First) HARRY (Middle) (NMI) (Last) JONES		4. DATE OF DEATH (Month) May (Day) 19 (Year) 51	
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 9-9-97
9. AGE last birthday 53 yrs.		10. If under 1 year: Months 19 Days 51 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10b. KIND OF BUSINESS OR INDUSTRY Transfer Co.	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME E. James Jones		14. MOTHER'S MAIDEN NAME Emma (NM Unknown)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT AND ADDRESS Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) **LOBAR PNEUMONIA, LEFT LOWER LOBE**

INTERVAL BETWEEN ONSET AND DEATH
UNKNOWN

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that **VA** attended the deceased from **May 17**, 19**51**, to **May 19**, 19**51**, and that death occurred at **9:20 A.** m., from the causes and on the date stated above.

SIGNATURE **George E. Maysatt M.D.** ADDRESS **VAH, Fort Howard, Maryland** DATE SIGNED **5-20-51**

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	5-21-51	Baltimore National	Baltimore, Maryland	

DATE REC'D BY LOCAL REG. **5/21/51** REGISTRAR'S SIGNATURE **J. W. Hedrick** 24. FUNERAL DIRECTOR **Isaiah L. Brown & Son** ADDRESS **108 W. Montgomery**

682 526 Street, Baltimore, Maryland

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04613

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Md. COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Catonsville		CITY (If outside corporate limits, write RURAL and give nearest town) Catonsville	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 101 Bloomsbury Ave.		STREET ADDRESS (If rural, give location) 101 Bloomsbury Ave.	
3. NAME OF DECEASED (First) (Middle) (Last) Sarah J. Kaehler		4. DATE (Month) (Day) (Year) OF DEATH May 12 1951	
5. SEX F	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED	8. DATE OF BIRTH April 6, 1862
		9. AGE last birthday 89 yrs.	If under 1 year If under 24 hrs. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Penna.
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Jame Devine	
14. MOTHER'S MAIDEN NAME Agnes Eckenrode		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS James Kaehler 101 Bloomsbury Av.	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Cardiac Failure			3 days.
Antecedent cause(s) (b) Arterio Sclerotic C.V. Disease			1 year
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT, SUICIDE, HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 2, 1951, to May 12, 1951, that I last saw the deceased alive on May 11, 1951, and that death occurred at 4 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 5-14-1951	NAME OF CEMETERY OR CREMATORY Cathedral Cemetery	LOCATION (City, town, or county) Baltimore, Md.	(State)
DATE REC'D BY LOCAL REG. 5/13/51	REGISTRAR'S SIGNATURE V.E. Harry	24. FUNERAL DIRECTOR George C. Taylor	ADDRESS Catonsville Md.	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 14 1961
BUREAU V. S.

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
TOWN <u>3125 Brenwal Rd.</u>		TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS <u>3125 Brenwal Rd.</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>LOUISA</u> (Middle) <u>B.</u> (Last) <u>KAHLER</u>		(Month) <u>May</u> (Day) <u>29</u> (Year) <u>1951</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>Nov. 9, 1875</u>
9. AGE last birthday <u>75</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Michael Scheeler</u>		14. MOTHER'S MAIDEN NAME <u>-----</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Eastern Ave.</u>		18. MEDICAL CERTIFICATION	
19. DATE OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>INJURY</u>		22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .	
23. BURIAL, CREMATION, REINTERMENT (Specify) <u>Burial</u>		24. FUNERAL DIRECTOR <u>Lassahn Funeral Home</u>	
DATE THEREOF <u>6/1/51</u>		ADDRESS <u>7401 Belair Rd.</u>	
NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cem.</u>		DATE SIGNED <u>5/29/51</u>	
LOCATION (City, town, or county) (State) <u>Balto. Md.</u>		SIGNATURE <u>W. J. Davis</u>	
DATE REC'D BY LOCAL REG. <u>5/29/51</u>		REGISTRAR'S SIGNATURE <u>W. J. Davis</u>	
TIME (Month) (Day) (Year) (Hour) <u>5/29/51</u>		HOW DID INJURY OCCUR? <u>While at work</u>	
INJURY OCCURRED <u>While at work</u>		INJURY OCCURRED <u>While at work</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>10 MIN</u>	
Immediate cause (a) <u>Cerebral Accident</u>		Antecedent cause(s) (b) <u>A-S-C-V Disease</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		5 yrs	
11. OTHER SIGNIFICANT CONDITIONS		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
Conditions contributing in the death but not related to the disease or condition causing death.		13. FATHER'S NAME <u>Michael Scheeler</u>	
14. MOTHER'S MAIDEN NAME <u>-----</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS <u>Eastern Ave.</u>	
18. MEDICAL CERTIFICATION		19. DATE OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>INJURY</u>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .		23. BURIAL, CREMATION, REINTERMENT (Specify) <u>Burial</u>	
24. FUNERAL DIRECTOR <u>Lassahn Funeral Home</u>		DATE THEREOF <u>6/1/51</u>	
ADDRESS <u>7401 Belair Rd.</u>		NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cem.</u>	
DATE SIGNED <u>5/29/51</u>		LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
SIGNATURE <u>W. J. Davis</u>		REGISTRAR'S SIGNATURE <u>W. J. Davis</u>	
DATE REC'D BY LOCAL REG. <u>5/29/51</u>		TIME (Month) (Day) (Year) (Hour) <u>5/29/51</u>	
INJURY OCCURRED <u>While at work</u>		HOW DID INJURY OCCUR? <u>While at work</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04615

Reg. Dist. No. 37

1. PLACE OF DEATH- COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Texas</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Texas</u>	
TOWN <u>Baltimore County Home</u>		TOWN <u>Texas</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>Texas</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>Paul</u> (Middle) <u>Kaminski</u> (Last)		(Month) <u>May</u> (Day) <u>30</u> (Year) <u>1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Jan. 27, 1884</u>
9. AGE last birthday <u>67</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farm laborer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>	11. BIRTHPLACE (State or foreign country) <u>Poland</u>
13. FATHER'S NAME <u>Frank Kaminski</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Baltimore Co. Home Records</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Coronary thrombosis

Antecedent cause(s)

(b) Coronary sclerosis

(c) stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH

5 min.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. duodenal ulcer

15 years

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Jan 1, 1951, to May 30, 1951, that I last saw the deceased

alive on May 28, 1951, and that death occurred at 7 P. m., from the causes and on the date stated above.

SIGNATURE Elizabeth B. Sherrill M.D. ADDRESS Cockeysville, Md. DATE SIGNED 5/30/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE THEREOF <u>6/1/1951</u>	NAME OF CEMETERY OR CREMATORY <u>SACRED HEART</u>	LOCATION (City, town, or county) <u>DUNDALK, Md.</u>	(State)
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DATE REC'D BY LOCAL REG. <u>May 31/51</u>	REGISTRAR'S SIGNATURE <u>Wm. J. Philcoat</u>	24. FUNERAL DIRECTOR, ADDRESS <u>Walter Burke Bradley, Dundalk, Md.</u>
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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 4 1951
BUREAU W.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04616

CERTIFICATE OF DEATH

Reg. Dist. No. 45

1. PLACE OF DEATH- COUNTY BALTO. MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Lancaster, PA COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Middle River LENGTH OF STAY 5 1/2 yrs				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lancaster, PA			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Ty. Hall-Nursing Home				STREET ADDRESS (If rural, give location) ✓			
3. NAME OF DECEASED (Type or Print) EMMA (First) EMMA (Middle) R. (Last) XAUTZ		4. DATE OF DEATH MAY 21 1951		5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) At Home		8. DATE OF BIRTH FEB 1 1864		9. AGE last birthday 86 87 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home	
11. BIRTHPLACE (State or foreign country) LANCASTER, PA		12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME CHARLES WALTER		14. MOTHER'S MAIDEN NAME BARNES	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY No. None		17. INFORMANT Geo. N. Young, 317 E. Orange St Lancaster PA.			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
Immediate cause (a) arteriosclerotic heart disease & hypertension				Paul 10 years			
Antecedent cause(s) (b) and cerebral hemorrhage, spontaneous							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) arteriosclerotic causing Hemiplegia left side							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. none.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT (Specify) SUICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan. 10, 1950 , to May 20, 1951 , that I last saw the deceased alive on May 20, 1951 , and that death occurred at 4:30 A.M. from the causes and on the date stated above.							
SIGNATURE Irving B. Beck		(Degree or title) M.D.		ADDRESS 901 E. Lombard St Baltimore 202nd		DATE SIGNED May 21, 1951	
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF 5/24/51		NAME OF CEMETERY OR CREMATORY Lancaster C. m.		LOCATION (City, town, or county) (State) Lancaster, PA.	
DATE REC'D BY LOCAL REG. May 24, 1951		REGISTRAR'S SIGNATURE Garth Hurley		24. FUNERAL DIRECTOR Lassahn Funeral Home		ADDRESS md. 7401 Belair Rd Balt Co	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DAVID

FEMALE WHITE

CHARLES WALTER

ROUTE
FEBRUARY 86
LANCASTER, PA
DANNES

1

MAY 21
1961
U.S.

RECEIVED
MAY 28 1961
BUREAU OF INVESTIGATION
U.S. DEPARTMENT OF JUSTICE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 40

04617

1. PLACE OF DEATH- COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Baldwin P.O.		CITY (If outside corporate limits, write RURAL and give nearest town) Baldwin P.O. (rural)	
TOWN Baldwin P.O.		TOWN Baldwin P.O.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sweet Air Road		STREET ADDRESS (If rural, give location) Sweet Air Road	
3. NAME OF DECEASED (Type or Print)	(First) CHARLES	(Middle) EDGAR	(Last) KING
4. DATE OF DEATH	(Month) May	(Day) 3	(Year) 1951
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Jan. 11, 1889
9. AGE last birthday 62 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Court Stenographer		10b. KIND OF BUSINESS OR INDUSTRY Circuit Court
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Arnold King		14. MOTHER'S MAIDEN NAME Julia Bowen	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY No. None	
17. INFORMANT AND ADDRESS Mrs. Robert T. Valdivia, Baldwin, Md.			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause		(a) General Arteriosclerosis		?	
Antecedent cause(s)		(b) Coronary Sclerotic Heart Dis.		4 mos.	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(c) Obliterative Endarteritis Upper & Lower Extremities		1 yr.	
II. OTHER SIGNIFICANT CONDITIONS		Thrombosis		2 da.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 2/4 , 19 51 to 5/3 , 19 51 , that I last saw the deceased alive on 5/3 , 19 51 , and that death occurred at 9 P. m., from the causes and on the date stated above.					
SIGNATURE Clifford F. Hudson M.D.		(Degree or title) Fark M.D.		DATE SIGNED 5/5/51	
23. BURIAL CREMATION REMOVAL (Specify) Burial		DATE May 7, 1951		NAME OF CEMETERY OR CREMATORY St. John's Catholic Cem.	
LOCATION (City, town, or county) Long Green, Balto. Co., Md.		24. FUNERAL DIRECTOR John Burns' Sons, Towson, Maryland		ADDRESS	
DATE REC'D BY LOCAL REG. May 5 1951		REGISTRAR'S SIGNATURE RW			

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

350936

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 04618

1. PLACE OF DEATH COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE md. COUNTY Balto.	
CITY (If outside corporate limits, write RURAL and give nearest town) Chase		CITY (If outside corporate limits, write RURAL and give nearest town) Chase	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Box 246 Rt. 14 Birdale Rd.		STREET ADDRESS (If rural give location) Box 246 Rt. 14 Birdale Rd.	
3. NAME OF DECEASED (Type or Print) MARIE	(First) E	(Middle) KREIGER	(Last)
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH Oct. 22 - 1892
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	9. AGE last birthday 58 yrs.
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME Mamie Schott / Hoyt	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY No. -	
17. INFORMANT Catherine Schott			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) **Cardiac arrest**

174X Antecedent cause(s) (b) **Cachexia, anemia**

48X Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) **Carcinoma uterus advanced**

3 YRS

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **May 30, 1950**, to **May 21, 1951**, that I last saw the deceased alive on **May 21, 1951**, and that death occurred at **2:20 p.m.**, from the causes and on the date stated above.

SIGNATURE Louis Semeroff	(Degree or title) MD	ADDRESS 1437 Tuselage Ave Balto 20 Md	DATE SIGNED May 21, 1951
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF May 24 - 1951	NAME OF CEMETERY OR CREMATORY Oak Lawn	LOCATION (City, town, or county) (State) Eastern Ave. Rd. - md.
DATE REC'D BY LOCAL REG. 5/23/51	REGISTRAR'S SIGNATURE K.W. Nedrich	24. FUNERAL DIRECTOR John B Connolly	ADDRESS Essex 21 - md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Items 2, 9 on:

No. G 1 MAY 24 1951

MARYLAND STATE DEPARTMENT OF HEALTH

04619

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 11

1. PLACE OF DEATH- COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE South Carolina Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Fort Howard		CITY (If outside corporate limits, write RURAL and give nearest town) OR Ridgeway Baltimore #1	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Vet. Adm. Hosp. Ft. Howard, Md.		STREET ADDRESS (If rural, give location) Rt 1. Box 19 247 N. Pearl St.	
3. NAME OF DECEASED (Type or Print) (First) TOM (Middle) H (Last) LAMAR		4. DATE OF DEATH (Month) May (Day) 18 (Year) 1951	
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH 10-31-25
9. AGE last birthday 25 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
11. BIRTHPLACE (State or foreign country) Ridgeway, S.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Tom Lamar		14. MOTHER'S MAIDEN NAME Maggie Hunter	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Y S W W I I		16. SOCIAL SECURITY No. 250-40-3844	
17. INFORMANT AND ADDRESS Clin. Rec. Vet. Adm. Hosp. Ft. Howard, Md.		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) Subacute Glomerulonephritis		unknown	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Cardiac Hypertrophy & Dilatation		unknown	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
INJURY			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from May 2 , 19 51 , to May 18 , 19 51 , and that death occurred at 7:40 P.m. , from the causes and on the date stated above.			
SIGNATURE LAWRENCE J. KNOX, M.D.		ADDRESS VAH Fort Howard, Maryland	
DATE SIGNED 5-18-51			
23. BURIAL, CREMATION REMOVAL (Specify) BURIAL		DATE THEREOF May 23, 1951	
NAME OF CEMETERY OR CREMATORY Mt. Pisgah		LOCATION (City, town, or county) (State) Ridgeway, S.C.	
24. FUNERAL DIRECTOR Charles R. Law, 802 Madison Ave. Balto. Md		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04620

Reg. Dist. No. 38

1. PLACE OF DEATH- COUNTY Baltimore		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE MD COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) Parkville		CITY (If outside corporate limits, write RURAL and give nearest town) Parkville	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location) 2302 Linwood Ave	
3. NAME OF DECEASED (Type or Print) Theresa Maria Lang		4. DATE OF DEATH (Month) May (Day) 24 (Year) 1957	
5. SEX Female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOW	8. DATE OF BIRTH Jan 7 1965
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY at home	9. AGE last birthday 86 yrs.
11. BIRTHPLACE (State or foreign country) Wash D C		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME C T Trautmann		14. MOTHER'S MAIDEN NAME Charlotte Mundlein	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No.	
17. INFORMANT George E Lang		2302 Linwood Ave	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 7
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) Arteriosclerotic Heart Disease - coronary		
Antecedent cause(s) (b) Heart - atherosclerotic, gradual, long standing		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Genit. Arteriosclerosis		
11. OTHER SIGNIFICANT CONDITIONS		
Conditions contributing to the death but not related to the disease or condition causing death. Kyphoscoliosis, Dorsal spine Swell		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from July 15, 1950, to May 24, 1957, that I last saw the deceased alive on May 24, 1957, and that death occurred at 3:30 P.M., from the causes and on the date stated above.		
SIGNATURE Donald W. Monte		DATE SIGNED 5/28/57
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF 4/20/57
NAME OF CEMETERY OR CREMATORY Loudon Park		LOCATION (City, town, or county) Balto. Md.
DATE REC'D BY LOCAL REG. 4/28/57		24. FUNERAL DIRECTOR Ullrich Funeral Home 204 Orleans St.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fort Howard</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Vets. Adm. Hosp. Ft. Howard, Md.</u>		STREET ADDRESS (If rural, give location) <u>1110 Parrish St.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>MAJOR</u>	(Middle) <u>(NMI)</u>	(Last) <u>LEE</u>
4. DATE OF DEATH	(Month) <u>May</u>	(Day) <u>18</u>	(Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>separated</u>	8. DATE OF BIRTH <u>12-25-93</u>
9. AGE last birthday <u>57</u> yrs.		10. If under 1 year: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Richmond, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Lee Major</u>		14. MOTHER'S MAIDEN NAME <u>Georgia MN Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>WW-1</u>		16. SOCIAL SECURITY No. <u>212-12-7185</u>	
17. INFORMANT AND ADDRESS <u>Clin. Rec. Vets. Adm. Hosp. Ft. Howard, Md.</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Hypertensive Cardiovascular Disease with renal failure</u>			<u>indefinite</u>
Antecedent cause(s) (b) <u>442X</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>131a</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>5-10</u> , 19 <u>51</u> , to <u>5-18</u> , 19 <u>51</u> , that I last saw the deceased <u>XXXXXX</u> , and that death occurred at <u>11:50 P.m.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Lawrence J. Knox, M.D.</u>		ADDRESS <u>VAH FORT HOWARD, MD.</u>	
DATE SIGNED <u>5-19-51</u>			
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <u>May 23, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Balto. National Cemetery</u>	LOCATION (City, town, or county) (State) <u>5501 Frederick Ave Balto. Md.</u>
DATE REC'D BY LOCAL REG. <u>5/21/51</u>	REGISTRAR'S SIGNATURE <u>Dr. Hadunk</u>	24. FUNERAL DIRECTOR ADDRESS <u>Kelson Funeral Home 1303 Presstman St. Balto</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

970000

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04622

Reg. Dist. No. *af*

1. PLACE OF DEATH- COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Port Howard		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Baltimore 2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Vet. Adm. Hosp., Ft. Howard, Md.		STREET ADDRESS (If rural, give location) 1116 McAleer Court	
3. NAME OF DECEASED (Type or Print)	(First) THOMAS	(Middle) J.	(Last) LENNERT
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	4. DATE OF DEATH May 12 1951
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Marine Engr.		10b. KIND OF BUSINESS OR INDUSTRY	8. DATE OF BIRTH 1-16-80
13. FATHER'S NAME John Lennert		14. MOTHER'S MAIDEN NAME Mary Richards	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 213-12-3664	9. AGE last birthday 71 yrs. <small>If under 1 year Months Days Hours Min.</small>
17. INFORMANT AND ADDRESS Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(a) Immediate cause PULMONARY TUBERCULOSIS, FAR ADVANCED, ACTIVE		UNKNOWN	
(b) Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last			
(c) OTHER SIGNIFICANT CONDITIONS Diabetes Mellitus Arteriosclerosis, generalized		UNKNOWN UNKNOWN	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office hldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from April 26, 1951 , to May 12, 1951 , and that death occurred at 4:13 P. m. , from the causes and on the date stated above.			
SIGNATURE <i>Samuel R. Pries</i>		ADDRESS VAH Fort Howard, Md.	
DATE SIGNED 5-12-51			
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF 5/15/51	
NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		LOCATION (City, town, or county) (State) Woodlawn, Md.	
DATE REC'D BY LOCAL REG. 5/14/51		24. FUNERAL DIRECTOR William Cook, Inc. St. Paul & Preston Sts. Baltimore, Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

2405-76

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 04623
31

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Randallstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Randallstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Clifmar Road</u>		STREET ADDRESS (If rural, give location) <u>Clifmar Road</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Elsie</u>	(Middle) <u>Mae</u>	(Last) <u>Lyons</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>May 16 19 51</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	8. DATE OF BIRTH <u>Dec. 17, 1884</u>	9. AGE last birthday <u>66</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Calvert County, Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	13. FATHER'S NAME <u>Wm Harvey Swann</u>	
14. MOTHER'S MAIDEN NAME <u>Emma Fowler</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY No. <u>No</u>		17. INFORMANT AND ADDRESS <u>J. Herbert Lyons, Clifmar Road, Randallstown</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Carcinoma of Ovaries - C</u>		<u>2 yrs.</u>
Antecedent cause(s) (b) <u>Met. to Liver and Ascites</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Congestive Heart Failure</u>		<u>1 week</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION <u>Feb. 1951</u>	19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma Ovaries - C Metastasis - Liver</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 1, 1950, to May 16, 1951, that I last saw the deceased alive on May 16, 1951, and that death occurred at 9:30 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE <u>May 19 1951</u>	NAME OF CEMETERY OR CREMATORY <u>St. Charles Cemetery, Randallstown, Md.</u>	LOCATION (City, town, or county) (State) <u>Randallstown, Md.</u>
DATE REC'D BY LOCAL REG. <u>5-17-51</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>Charles Amoreau</u>	ADDRESS <u>4510 W. 49th Ave</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 33

04624

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md</u> COUNTY <u>Haw</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cumy Mills</u> LENGTH OF STAY (in this place) <u>2 mos 4 da</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Belair, Md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rosewood State Tr. School</u>		STREET ADDRESS (If rural, give location) <u>23 S. Main St.</u>	
3. NAME OF DECEASED (First) <u>Judy</u> (Middle) <u>Magness</u> (Last) <u>Magness</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>17</u> (Year) <u>1951</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>11/7/50</u>
9. AGE last birthday <u>0 yrs. 6 mos. 10 days</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>Starford Memorial Hospital</u>		12. CITIZEN OF WHAT COUNTRY? <u>Starford</u>	
13. FATHER'S NAME <u>Edward Magness</u>		14. MOTHER'S MAIDEN NAME <u>Chanta J. Endrey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Rosewood - Cumy Mills, Md</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) meningitis, purulent, acute

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) hydrocephalus congenital with complical(c) ing pressure ulcer

INTERVAL BETWEEN ONSET AND DEATH

3 day -

Birth -

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

19a. DATE OF OPERATION none

19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

HOMICIDE INJURY

TIME (Month) (Day) (Year) (Hour) INJURY OCCURRED HOW DID INJURY OCCUR?

OF While at Not While

INJURY m. Work ☐ At work ☐

20. AUTOPSY?

Yes ☐ No ☒

22. I hereby certify that I attended the deceased from 17 May, 1951, to 17 May, 1951, that I last saw the deceased alive on 17 May, 1951, and that death occurred at 6 P.m., from the causes and on the date stated above.

SIGNATURE: H. B. Barker M.D. ADDRESS: Cumy Mills, Md DATE SIGNED: 17 May '51

23. BURIAL, CREMATION REMOVAL (Specify) DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)

Burial May 19, 1951 Baptist Church Four Mile, Howard Co MD

DATE REC'D BY LOCAL REG. 5-29-51 REGISTRAR'S SIGNATURE Howard K. McCombs & Son ADDRESS Abingdon Rd

20X070242373

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 415

RECEIVED
JUN 17 1964
BUREAU V. S.

Item 4 Gilm G133 6/8/51 wlv.
Items 1,5,6 Film G134 7/19/51

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04625

Reg. Dist. No. 40

1. PLACE OF DEATH- COUNTY <i>Balt Co.</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <i>md.</i> COUNTY <i>Balt Co.</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Hydes</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Hydes Md.</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <i>Grace</i> (Middle) <i>Arnold</i> (Last) <i>Mast</i>	4. DATE OF DEATH (Month) <i>May</i> (Day) <i>26</i> (Year) <i>1951</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Feb. 19-1896</i>
9. AGE last birthday <i>55</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Bookkeeper</i>	
11. BIRTHPLACE (State or foreign country) <i>Balt Md.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Harry A. Bayne</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>2A-22-9105</i>	
17. INFORMANT AND ADDRESS <i>Mrs. Sophia Bicknerstoffs Hydes End</i>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <i>Intestinal Obstruction</i>		<i>2 days</i>	
Antecedent cause(s) (b) <i>Carcinoma Sigmoid colon</i>		<i>8 mos.</i>	
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <i>Feb. 1951</i>		19b. MAJOR FINDINGS OF OPERATION <i>Carcinoma Sigmoid Colon + Metastasis</i>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>3/5</i> , 19 <i>51</i> , to <i>5/26</i> , 19 <i>51</i> , that I last saw the deceased alive on <i>5/26</i> , 19 <i>51</i> , and that death occurred at <i>4 P.</i> m., from the causes and on the date stated above.			
SIGNATURE <i>Clifford F. Hudson</i>		DATE SIGNED <i>5/27/51</i>	
23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>May 29-51</i>	
NAME OF CEMETERY OR CREMATORY <i>Fork M. Cemetery</i>		LOCATION (City, town, or county) (State) <i>Fork Md.</i>	
24. FUNERAL DIRECTOR <i>C. E. Arthur</i>		ADDRESS <i>Fork Md.</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

784367

BUREAU U. S.

JUN 6 1951

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04626

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE <u>Md.</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Liberty Road</u>		STREET ADDRESS (If rural, give location) <u>Liberty Rd.</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Grafton Thomas Maynard Sr.</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May 4, 1951</u> 19	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug. 16, 1887</u>
9. AGE last birthday <u>63</u> yrs.		10. USUAL OCCUPATION (Give kind of work and duration of working life, even if retired) <u>Vice President Forest Distillery Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Benjamin Maynard</u>		14. MOTHER'S MAIDEN NAME <u>Emma Carter</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Orilla Hulse Maynard</u>		18. MEDICAL CERTIFICATION <u>Randallstown, Md.</u>	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>3 WKS</u>	
Immediate cause (a) <u>Cerebral Hemorrhage</u>			
Antecedent cause(s) (b) <u>Hypertensive Cardiovascular Disease</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Arteriosclerosis</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>Oct 25</u> , 19 <u>47</u> to <u>May 4</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>May 2</u> , 19 <u>51</u> and that death occurred at <u>10:10 P.m.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Lester Leles M.D.</u>		DATE SIGNED <u>May 4, 1951</u>	
23. BURIAL, CREMATION OR REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>May 8/51</u>	
NAME OF CEMETERY OR CREMATORY <u>Lorraine Pk.</u>		LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
DATE REC'D BY LOCAL REG. <u>5/1/51</u>		FUNERAL DIRECTOR <u>AW. Hedrich</u> ADDRESS <u>4101 Edmondson Ave.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

290418

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04627

Reg. Dist. No.

1. PLACE OF DEATH: Woodstock College, Woodstock COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) Rural TOWN		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Woodstock,	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Woodstock, Maryland		STREET ADDRESS (If rural, give location) Woodstock College, Woodstock, MD.	
3. NAME OF DECEASED (Type or Print)	(First) William	(Middle) Hildrup	(Last) McCLELLAN, S.J.
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE	4. DATE OF DEATH (Month) May (Day) 8 (Year) 1951
8. DATE OF BIRTH MAR. 25. 1874	9. AGE last birthday 77 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Priest - Educator	
10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) West Chester, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME ROBERT MILLER McCLELLAN	14. MOTHER'S MAIDEN NAME ELLA HILDRUP		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY No. X	17. INFORMANT Francis X. PEIRCE, S.J. (Woodstock College)	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) Myocarditis		
Antecedent cause(s) (b) Cerebral accidents III	1944-50-51	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) arteriosclerosis. Senility.		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1949, 19....., to 1951, 19....., that I last saw the deceased alive on May 7, 1951, and that death occurred at 4:15 A.M., from the causes and on the date stated above.

SIGNATURE Harold H. Burns ADDRESS 115 E. EAGER ST. Baltimore 2 md.

23. BURIAL, CREMATION, REMOVAL (Specify) DATE 5-11-51 NAME OF CEMETERY OR CREMATORY Woodstock College Crem. Woodstock Md. LOCATION (City, town or county) (State)

DATE REC'D BY LOCAL REG. 5/9/51 REGISTRAR'S SIGNATURE B.W. Hedrick 24. FUNERAL DIRECTOR ADDRESS Bernard E. Haule 121 W. 009896 E West St

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04628

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>PIKESVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>PIKESVILLE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>9 Church Lane</u>		STREET ADDRESS (If rural, give location) <u>9 Church Lane</u>	
3. NAME OF DECEASED (Type or Print) <u>BASIL</u> (First) <u>F. Mc Kim</u> (Middle) <u></u> (Last)		4. DATE OF DEATH (Month) <u>5</u> (Day) <u>21</u> (Year) <u>1951</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>5/18/1870</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Builder - for self</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	9. AGE last birthday <u>81</u> yrs. If under 1 year: Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
11. BIRTHPLACE (State or foreign country) <u>CONCORD PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u></u>	
13. FATHER'S NAME <u>JOHN Mc KIM</u>		14. MOTHER'S MAIDEN NAME <u>CAROLINE DOYLE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY No. <u></u>	
17. INFORMANT <u>KATHERINE Mc KIM, 9 Church Lane</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a)

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN ONSET AND DEATH

4 yrs
2 yrs21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY?

Yes ☐ No ☐TIME (Month) (Day) (Year) (Hour)
OF INJURYINJURY OCCURRED
While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Arrangements to 5-21, 1951, that I last saw the deceasedalive on 5/21, 1951, and that death occurred at 10 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION
REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

5/22/51Dr. E. McNealFrank H. NewellPikesville Md.

290246

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAY 24 1951
BUREAU W. S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

04629

Reg. Dist. No. 30

1. PLACE OF DEATH - COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	
TOWN <u>Catonsville</u>		TOWN <u>Catonsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>		STREET ADDRESS (If rural give location) <u>Spring Grove State Hospital</u>	
3. NAME OF DECEASED (First) <u>PHILIP</u> (Middle) (Last) <u>MEHRING</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>15</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>single</u>	8. DATE OF BIRTH <u>Nov. 29, 1868</u>
9. AGE last birthday <u>82</u> yrs.		10. If under 1 year: Months <u>5</u> Days <u>13</u> Hours <u>13</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Phillip Mehrling</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ruppel</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. _____	
17. INFORMANT <u>Hospital Records, Catonsville 28, Md.</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Total Pneumonia</u>			
Antecedent cause(s) (b) <u>fracture right femur</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>May 12 1951 4:30 p.m.</u>		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
HOW DID INJURY OCCUR? <u>slipped on floor falling back</u>		(CITY OR TOWN) <u>Catonsville</u> (COUNTY) <u>Baltimore</u> (STATE) <u>Md.</u>	
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>			
SIGNATURE <u>Dr. M. L. Kupper</u>		ADDRESS <u>1010 Leeds on May 15, 51</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		DATE THEREOF <u>5/17/51</u>	
NAME OF CEMETERY OR CREMATORY <u>Violetville Cemetery</u>		LOCATION (City, town, or county) (State) <u>Violetville, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>5-16-51</u>		REGISTRAR'S SIGNATURE <u>W. Cook</u>	
24. FUNERAL DIRECTOR <u>W. Cook Inc.</u>		ADDRESS <u>1212 St. Paul St.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

04630

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. **43**

1. PLACE OF DEATH- COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE MARYLAND COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) Fullerton		CITY (If outside corporate limits, write RURAL and give nearest town) FULLERTON	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Ridge Road		STREET ADDRESS (If rural, give location) Box 490 A1 Ridge Rd Fullerton, Md.	
3. NAME OF DECEASED (Type or Print) MINNI VAHATALLO (First) MIETTINEN (Last)		4. DATE OF DEATH May 22, 1951 (Month) (Day) (Year)	
5. SEX F	6. COLOR OF RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOW	8. DATE OF BIRTH Nov. 1, 1893
			9. AGE last birthday 57 yrs. If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY At home	
11. BIRTHPLACE (State or foreign country) Finland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT AND ADDRESS Fullerton, Md.		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

160X Immediate cause

55d

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a) **Myocardial insufficiency** 3 weeks

(b) **Coronary artery disease**

(c) **with metastases in lymph nodes** 3 hours

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION Sept 1950	19b. MAJOR FINDINGS OF OPERATION Biopsy showed carcinoma	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, or office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **March 1, 1951**, to **May 22, 1951**, that I last saw the deceasedalive on **May 22**, 1951, and that death occurred at **11 A.M.**, from the causes and on the date stated above.SIGNATURE **S. E. Carson**

(Degree or title)

ADDRESS **100 Overlook Rd. Baltimore, Md.**DATE SIGNED **May 22, 1951**

23. BURIAL, CREMATION REMOVAL, (Specify) Burial	DATE THEREOF 5/25/51	NAME OF CEMETERY OR CREMATORY Oaklawn Cemetery	LOCATION (City, town, or county) Baltimore, Md.	(State)
DATE REC'D BY LOCAL REG. 5-24-51	REGISTRAR'S SIGNATURE [Signature]	24. FUNERAL DIRECTOR Henry Sander & Sons, Inc.	ADDRESS BALTO., 13, MD	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04631

Reg. Dist. No. 33

1. PLACE OF DEATH: **Baltimore**
 County.....
 City or town..... **Owings Mills**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? **5 years**
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... **Maryland** County..... **Baltimore**
 City or town..... **Owings Mills**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. **20 Ritters Lane**
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... **no**

3. (a) FULL NAME
FRANCIS M. G. MILLS
 4. Sex **male** 5. Color or race **white** 6.(a) Single, married, widowed, or divorced **married**
 6.(b) Name of husband or wife..... **Flora E. Mills**
 6.(c) If alive, give age **76 yrs**
 7. Birth date of deceased (mo., day, yr.) **Sept. 12, 1870**
 8. AGE: Years **80** Months Days If less than one day hrs. min.

9. Birthplace..... **Maryland**
 (Town, county, and state)
 10. Usual occupation..... **Carpenter (retired)**
 11. Industry or business.....
 12. Name..... **Malachi M. Mills**
 13. Birthplace..... **Md.**
 14. Maiden name..... **Mary C. Gosnell**
 15. Birthplace..... **Md.**
 16. Informant..... **Mrs. Flora E. Mills**
 Address..... **Owings Mills, Md.**
 17. **Burial** Date thereof..... **6-2-1951**
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... **Morgan Chapel**
 Location..... **Carroll Co. Md.**
 18. Funeral director..... **C. M. Waltz**
 Address..... **Winfield, Md.**
 19. **5-31-** 19 **51** **Mary B. Eline**
 (Date rec'd by registrar) Registrar

3. (b) Social Security Number
none

MEDICAL CERTIFICATION

20. DATE OF DEATH..... **5-30-51** at **9p**
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **1-1-49** to **5-30-51**
 and that I last saw him **14** alive on **5-30-51**
 Immediate cause of death..... **Myocarditis**
hypertension & compensatory
hypertrophy
 Due to.....
arteriosclerosis
 Due to.....
 Other conditions.....
443x
93d (Include pregnancy within 8 months of death)
 Major findings of operations.....
 Date of op.

DURATION

3yrs

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?
 23. SIGNATURE..... **James G. Saffell**
Beattie town M. D. or other **15/30/57**
 Address..... Date signed.....
516246

RECEIVED
JUN 21 1954
BUREAU K. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04632

Reg. Dist. No.

1. PLACE OF DEATH:

County Princess AnneCity or town Edgewater Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 weeks

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. CountyCity or town Baltimore Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. 1124 Wilcox Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Anna W. Womery4. Sex F. 5. Color or race W 6.(a) Single, married, widowed, or divorced M6.(b) Name of husband or wife Frank J. Womery7. Birth date of deceased (mo., day, yr.) Jan 11 18928. AGE: Years 59 Months Days It less than one day
..... hrs. min.9. Birthplace Balto Md
(Town, county, and state)10. Usual occupation House Wife

11. Industry or business

12. Name Edward French13. Birthplace Balto. Md14. Maiden name Amie Savona15. Birthplace 1124 Wilcox St16. Informant Frank J. WomeryAddress 1124 Wilcox St17. Burial Date thereof June 4 - 1951
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Holy RedeemerLocation Blair Road18. Funeral director Martin J. ConnorAddress 5020 Brothwood Rd19. 6/1 19 51 R. W. Hedrick
(Date rec'd by registrar) Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31 19 51, at 5:50 am21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 19 34, to May 31 19 51and that I last saw him alive on May 30 19 51Immediate cause of death Melanotic Carcinoma

DURATION

of Right Lung 1 1/2 yrsDue to Metastatic CarcinomaDue to Sciurus Carcinomaof Left Breast 16 1/2Other conditions 170X50 (Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

Signature William R. GerschlagerM.D. or other 6/1/51Address 10 E. Biddle St Date signed 6/1/51

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04633

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u> TOWN <u>Woodlawn</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>6404 Liberty Road.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Balto.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u> TOWN <u>Woodlawn</u> STREET ADDRESS (If rural, give location) <u>6404 Liberty Road.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>James</u> (Middle) <u>Fredrick</u> (Last) <u>Moore Sr.</u>	4. DATE OF DEATH	(Month) <u>May</u> (Day) <u>5</u> (Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan 19 1899</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>High School</u>	9. AGE last birthday <u>52</u> yrs.	11. BIRTHPLACE (State or foreign country) <u>Mellon, Pa.</u>
13. FATHER'S NAME <u>Joseph R. Moore</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	14. MOTHER'S MAIDEN NAME <u>Clanor M. Mung.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>	16. SOCIAL SECURITY No. <u>4-108-1451</u>	17. INFORMANT AND ADDRESS <u>Mrs. Claude M. Moore 6404 Liberty Rd</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 Immediate cause (a) Coronary Thrombosis
Antecedent cause(s) (b) None
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) None

INTERVAL BETWEEN ONSET AND DEATH
One hour

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 4, 1951, to May 5, 1951, that I last saw the deceased alive on May 5, 1951, and that death occurred at 3:45 A.M., from the causes and on the date stated above.

SIGNATURE <u>Earl L. Chapman</u>	(Degree or title) <u>M.D.</u>	ADDRESS <u>4108 Liberty Hts Balto</u>	DATE SIGNED <u>5-5-51</u>
23. BURIAL, CREMATION REMOVAL, (Specify) <u>Burial</u>	DATE THEREOF <u>May 8 1951</u>	NAME OF CEMETERY OR CREMATORY <u>HARMONY CEMETERY</u>	LOCATION (City, town, or county) (State) <u>Mellon Pa</u>
DATE REC'D BY LOCAL REG. <u>6/7/51</u>	REGISTRAR'S SIGNATURE <u>Rev. Redmond</u>	24. FUNERAL DIRECTOR <u>William Lawrence</u>	ADDRESS <u>4510 Liberty Hts</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04634

CERTIFICATE OF DEATH

Reg. Dist. No. 35-

1. PLACE OF DEATH- COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>BALTIMORE</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WHITE HALL</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WHITE HALL</u>	
TOWN <u>WHITE HALL</u>		TOWN <u>WHITE HALL</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>VERNON ROAD</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>JOHN</u> <u>THOMAS</u> <u>MOORE</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>MAY</u> <u>28</u> <u>1947</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>NOV-15-1866</u>
10a. USUAL OCCUPATION (Give kind of work done, during most of working life, even if retired) <u>RETIRED FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>	9. AGE last birthday <u>84</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>THOMAS O. MOORE</u>		14. MOTHER'S MAIDEN NAME <u>MARY BURNS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY No. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>LEVINA E. MOORE WHITE HALL, MD</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Renal failure</u>		Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Arterio-Sclerosis</u> (c)	<u>2 weeks</u>
Antecedent cause(s) (b) <u>Arterio-Sclerosis</u>			<u>Several years</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>May 12, 1957</u> , to <u>May 28, 1957</u> , that I last saw the deceased alive on <u>May 28, 1957</u> , and that death occurred at <u>6:30 P.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Whitner Bortner M.D.</u>		ADDRESS <u>White Hall Md</u>	DATE SIGNED <u>May 28, 1957</u>
23. BURIAL CREMATION REMOVAL (Specify)		DATE <u>MAY-30-57</u>	NAME OF CEMETERY OR CREMATORY <u>BETHEL</u>
LOCATION (City, town, or county) <u>WHITE HALL, RURAL</u>		(State) <u>MD</u>	
DATE REC'D BY LOCAL REG. <u>May 29-57</u>		REGISTRAR'S SIGNATURE <u>Mrs. Howard S. Markline</u>	FUNERAL DIRECTOR <u>Howard S. Markline, White Hall, Md</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

100105

BUREAU OF

JUN 4 1951

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

04635

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH - COUNTY <u>Parkville</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Parkville</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3007 California Ave.</u>		STREET ADDRESS (If rural, give location) <u>3007 California Ave.</u>	
3. NAME OF DECEASED (Type or Print) <u>St Anastasia</u> (First) <u>Y Long</u> (Middle) <u>Moulds</u> (Last)		4. DATE OF DEATH <u>May 10 - 1957</u> (Month) (Day) (Year)	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <u>Married</u>	8. DATE OF BIRTH <u>Sept 12 - 1880</u>
9. AGE last birthday <u>70</u> yrs.		10. AGE last birthday If under 1 year If under 24 hrs. Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		11b. KIND OF BUSINESS OR INDUSTRY	
12. FATHER'S NAME <u>James Cloke</u>		13. MOTHER'S MAIDEN NAME <u>Biddie Leary</u>	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		15. SOCIAL SECURITY NO.	
16. INFORMANT AND ADDRESS <u>Mr. James Moulds, 3007 California</u>		17. MEDICAL CERTIFICATION	
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH, Immediate cause (a) <u>Chronic Myocarditis (Infestations)</u>		INTERVAL BETWEEN ONSET AND DEATH	
Antecedent cause(s) (b) <u>422.2 93d</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
19. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>Jan 1, 1949</u> , to <u>5/10/57</u> , that I last saw the deceased alive on <u>5/10</u> , 1957, and that death occurred at <u>5:30 P</u> m., from the causes and on the date stated above.			
SIGNATURE <u>W. V. Goss</u>		ADDRESS <u>5703 Harford Rd</u>	
DATE SIGNED <u>5/11/57</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>5/14/57</u>	
NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REG. <u>5-14-57</u>		REGISTRAR'S SIGNATURE <u>A. W. Nadrich</u>	
24. FUNERAL DIRECTOR <u>J. Luck</u>		ADDRESS <u>5305 Harford Road</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

04636

Reg. Dist. No. 3.....

Reg. Dist. No. 3.....

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause		(a) <i>Cerebral Hemorrhage</i>			
Antecedent cause(s)		(b) <i>chronic nephritis - stone bladder</i>		<i>5 yrs</i>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>May 1</i> , 19 <i>57</i> , to <i>May 15</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>May 15</i> , 19 <i>57</i> , and that death occurred at <i>6 P</i> m., from the causes and on the date stated above.					
SIGNATURE		(Degree or title)		ADDRESS	
<i>Sam A. Sullivan M.D.</i>		<i>2529</i>		<i>Genevieve Ave. Baltimore</i>	
23. BURIAL, CREMATION REMOVAL (Specify)		DATE		NAME OF CEMETERY OR CREMATORY	
<i>Burial</i>		<i>5/18/57</i>		<i>Pleasant Rest</i>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR	
<i>5-17-57</i>		<i>A.</i>		<i>Samuel W. Sullivan Jr.</i>	
				ADDRESS	
				<i>Baltimore, Md.</i>	

VS. A157

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5028

13/a

820105

MARYLAND STATE DEPARTMENT OF HEALTH

04637

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Balto. Co.</u> <u>Dundalk</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>265 Riverside Ave</u> OR TOWN <u>Life</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>—</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Balto.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>265 Riverside Ave</u> OR TOWN <u>Balto Dundalk</u> STREET ADDRESS (If rural, give location) <u>—</u>	
3. NAME OF DECEASED (Type or Print) <u>Bernard L. Ostendorf</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>19th</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug 7th 1883</u>
9. AGE last birthday <u>67</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>are</u>	
13. FATHER'S NAME <u>Joseph Ostendorf</u>		14. MOTHER'S MAIDEN NAME <u>Johanna Rettman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-03-5433</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) myocarditis, acute

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) arteriosclerosis(c) chronic, myocarditis

INTERVAL BETWEEN ONSET AND DEATH

1 day.8 yrs8 mos.II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Nov. 1946, to May 19, 1951, that I last saw the deceased alive on May 14, 1951, and that death occurred at 11:15 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>May 22, 1951</u>	<u>Parkwood</u>	<u>Taylor Ave</u>	<u>Balto</u>
DATE RECD BY LOCAL REG.	REGISTERAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>5/21/51</u>	<u>W. H. Hedrick</u>	<u>Leah Hook</u>	<u>1701-032 Patterson Park Ave</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

04638

Reg. Dist. No. 42

1. PLACE OF DEATH - COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>md</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Habichtshope</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Habichtshope</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4501 Maple an</u>		STREET ADDRESS (If rural, give location) <u>4501 Maple an</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Joseph</u> (Middle) <u>Raymond</u> (Last) <u>Oxworth</u>	4. DATE OF DEATH (Month) <u>May</u> (Day) <u>16</u> (Year) <u>1957</u>	
5. SEX <u>m</u>	6. COLOR OR RACE <u>w</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>May 10 1874</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Elevator Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>77</u> yrs. If under 1 year Months Days If under 24 hrs Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>usa</u>	
13. FATHER'S NAME <u>Samuel W Oxworth</u>		14. MOTHER'S MAIDEN NAME <u>Crosby</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>083.03.5630</u>	
17. INFORMANT AND ADDRESS <u>James M Oxworth Habichtshope md</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Acute cardiac failure</u>		
Antecedent cause(s) (b) <u>Coronary vascular disease</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE Dr. M. Kieffer (Degree or title) ADDRESS 1010 E. Leaden DATE SIGNED May 16 57

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>5-19-57</u>	NAME OF CEMETERY OR CREMATORY <u>Western Cam</u>	LOCATION (City, town, or county) <u>Baltimore md</u> (State)
DATE REC'D BY LOCAL REG <u>May 16 57</u>	REGISTRAR'S SIGNATURE <u>Dr. Kieffer</u>	24. FUNERAL DIRECTOR <u>Charles P. Sonell</u>	ADDRESS <u>421 Edmondson</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 21 1951
ST. PAUL, MINN.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04639

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>TOWSON</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>TOWSON</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>630 Yarmouth Rd.</u>		STREET ADDRESS (If rural, give location) <u>630 Yarmouth Rd.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>FRANCES</u>	(Middle) <u>REBECCA</u>	(Last) <u>PARTRIDGE</u>
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>married</u>	8. DATE OF BIRTH <u>Oct. 24, 1895</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	9. AGE last birthday <u>55</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>?</u>	
13. FATHER'S NAME <u>Thomas J. Carroll</u>		14. MOTHER'S MAIDEN NAME <u>Bridget</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Mr. Gilbert D. Partridge - 630 Yarmouth Rd</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Myocardial infarctionINTERVAL BETWEEN
ONSET AND DEATH35 minutes

Antecedent cause(s)

Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause last(b) Coronary occlusions - multiple since1947(c) Coronary arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not
related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Not Whillo Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 21 July....., 1947., to 21 May....., 1951., that I last saw the deceasedalive on 21 May....., 1951., and that death occurred at 9:35 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

J. Douglas Lockard, M.D.802 Cathedral St., Baltimore - Md 23 May, 1951

23. BURIAL, CREMATION REMOVAL (Specify) Removal	DATE THEREOF <u>5/24/51</u>	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) <u>Scranton, Pa.</u>	(State)
DATE REC'D BY LOCAL REG. <u>5/23/51</u>	REGISTRAR'S SIGNATURE <u>a.w. Redlich</u>	24. FUNERAL DIRECTOR <u>Wm. J. Fickner</u>	ADDRESS <u>Balto Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04640

CERTIFICATE OF DEATH

Reg. Dist. No. 35

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Phoenix</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Phoenix</u>	
TOWN <u>Phoenix</u>		TOWN <u>Phoenix</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Manor Road</u>		STREET ADDRESS (If rural, give location) <u>Manor Road</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Hattie</u>	(Middle) <u>Silver</u>	(Last) <u>Pardue</u>
4. DATE OF DEATH	(Month) <u>May</u>	(Day) <u>30</u>	(Year) <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>8 January 1876</u>
9. AGE last birthday <u>75</u> yrs.	If under 1 year <u>4</u> Months	If under 1 year <u>22</u> Days	If under 24 hrs. <u>22</u> Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Phoenix, Balto. Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Gittings Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Hattie Silver</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>-</u>	
17. INFORMANT AND ADDRESS <u>Eleanor Elizabeth Buckingham Baldwin Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Cardiac Decompensation

INTERVAL BETWEEN ONSET AND DEATH

1 yrs.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arteriosclerosis-generalized10 yrs.(c) Arteriosclerotic Heart Disease5 yrs

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb., 1951, to May, 1951, that I last saw the deceasedalive on 24 May, 1951, and that death occurred at 5:30 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Walter T. KeesM.D.Cockeysoille, Md.30 May 1951

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

June 1-1951Mrs. Harold S. MarklinMartin G. Kurtz, Garnettsville, Md.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

RECEIVED
JUN 6 1961
BUREAU K. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04641

Reg. Dist. No. 15

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD.</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Arbutus</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>ARBUTUS</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3315 WASHINGTON BLVD</u>		STREET ADDRESS (If rural give location) <u>3315 WASHINGTON BLVD.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>JAMES</u>	(Middle) <u>R.</u>	(Last) <u>PETWAY JR</u>
4. DATE OF DEATH	(Month) <u>5</u>	(Day) <u>28</u>	(Year) <u>1957</u>
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>JAN. 4. 1912</u>
9. AGE last birthday <u>34</u> yrs.		10. a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRUCK DRIVER</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>ASSD. TRANSPORT.</u>		11. BIRTHPLACE (State or foreign country) <u>WILSON N.C.</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>JAMES R. SR.</u>	
14. MOTHER'S MAIDEN NAME <u>ESSIE SMITH</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>	
16. SOCIAL SECURITY No.		17. INFORMANT <u>ELIZABETH PETWAY 3315 Wash. Blvd</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Rheumatic Heart Disease

INTERVAL BETWEEN ONSET AND DEATH

8 months

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) _____

(c) _____

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from November 19. 50, to May 19. 51, that I last saw the deceased

alive on May 26. 51, and that death occurred at 7:30 a.m., from the causes and on the date stated above.

SIGNATURE may

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Removal</u>	<u>5/29/51</u>	<u>Wilson N.C.</u>	<u>Wilson N.C.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>5/29/51</u>	<u>A W Hedrick</u>	<u>Blavenn & Hoffman</u>	<u>1639 Broadway</u>	

683 526

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04642

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Baltimore Co</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Balto. Co</u> LENGTH OF STAY (in this place) <u>3 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Chase, Md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>North River Shore</u>		STREET ADDRESS (If rural, give location) <u>Warewood Park, Md</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Theresa</u> <u>Gertrude</u> <u>Powers</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May</u> <u>8</u> <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>9/25/1874</u>
9. AGE last birthday <u>76</u> yrs.		10. AGE last birthday If under 1 year If under 24 hrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Bethersville</u>		12. CITIZEN OF WHAT COUNTRY? <u>Balto Co.</u>	
13. FATHER'S NAME <u>Joseph Smith</u>		14. MOTHER'S MAIDEN NAME <u>Annie J. Von Erda</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Gertrude P. Powers 2 North River</u>		18. MEDICAL CERTIFICATION <u>decent</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Cerebro-Vascular - accident</u>		<u>5-6-51</u>	
Antecedent cause(s) (b) <u>Arterio-sclerotic Cardio-Vascular disease</u>		<u>1 yr</u>	
(c) <u>Diabetes Mellitus</u>		<u>2 yrs</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
(CITY OR TOWN)		(COUNTY)	
(STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Not While Work <input type="checkbox"/> At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 1</u> , 19 <u>50</u> , to <u>5-8</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>5-6</u> , 19 <u>51</u> , and that death occurred at <u>11:45 P.m.</u> , from the causes and on the date stated above.			
SIGNATURE <u>J. M. Baumgardner MD</u>		DATE SIGNED <u>5-8-51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>May 11, 1951</u>	
NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		LOCATION (City, town, or county) (State) <u>Woodlawn, Balto. Co., Md.</u>	
DATE REC'D BY LOCAL REG. <u>5/11/51</u>		REGISTRAR'S SIGNATURE <u>R.W. Hechler</u>	
24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04643

Reg. Dist. No. 38

1. PLACE OF DEATH: Rogers Forge
County.....
City or town..... Baltimore
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
34 DUNKIRK Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... Maryland County..... Rogers Forge
City or town..... Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 34 DUNKIRK Road
(If rural, give LOCATION)
2(a) If veteran, name war

3. (a) FULL NAME
Ewart Gordon Price

3. (b) Social Security Number

4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife ONEITA Price

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) Dec. 16-1898

8. AGE: Years 52 Months Days If less than one day hrs. min.

9. Birthplace Somerset Co., Md.
(Town, county, and state)

10. Usual occupation ACCOUNTANT gas co

11. Industry or business

12. Name GUSTAVE Price

13. Birthplace Md

14. Maiden name SARAH TARLETON

15. Birthplace Md.

16. Informant MRS. ONEITA Price

Address 34 DUNKIRK Rd.

17. Burial Date thereof 5-31-1951
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory OAKLAWN

Location BALTO. Md.

18. Funeral director L. J. Ruck

Address 5305 Harford Rd.

19. 5/31 19 57 a w h d m n
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28, 1957, at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Medical Examination Case 19

and that I last saw h..... alive on 19

Immediate cause of death.....

DURATION

Coronary Occlusion Sudden

Due to 420.1

Due to 94a

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

John F. Green, M.D.

23. SIGNATURE Deputy Medical Examiner

Address 700 N. E. St. Date signed 5/28/57

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04644

Reg. Dist. No. 38

1. PLACE OF DEATH:

County BaltimoreCity or town Notch cliff near Towson
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Notch cliff near Towson
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Sister Mary Vincentia Puff

3. (b) Social Security Number

—

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Single

6.(b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) Dec. 26, 1879 6.(c) If alive, give age _____ years8. AGE: Years Months Days If less than one day
71 4 7 _____ hrs. _____ min.9. Birthplace Germany
(Town, county, and state)10. Usual occupation Teacher 420.111. Industry or business 94a12. Name Simon Puff13. Birthplace Germany14. Maiden name Mary Zimmerman15. Birthplace Germany16. Informant Sr. Mary ClaraAddress Notch cliff, Md.17. BURIAL Date thereof MAY 5, 1951
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory VILLA MARIA CEM.Location NOTCH CLIFF NR TOWSON.18. Funeral director Charles S. FeilerAddress 901 S. CONKLING ST. BALTO. 24 MD.19. 5/3/51 19 aw. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3 19 51 at 5.30 A. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Aug. 18 19 48 to May 3 19 51and that I last saw her alive on May 2 19 51Immediate cause of death Cerebral arteriosclerosis

DURATION

1 wk

Due to _____

Due to _____

Other conditions Arterio-sclerosis

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE John H. ... M.D. M. D. or other

Address _____ Date signed _____

04644

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04645

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Md. COUNTY Balto.	
CITY (If outside corporate limits, write RURAL and give nearest town) Rosedale		CITY (If outside corporate limits, write RURAL and give nearest town) Rosedale	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 7911 E. 33rd. St.		STREET ADDRESS (If rural, give location) 7911 E. 33rd. St.	
3. NAME OF DECEASED (Type or Print) JOHN (First) RADEMACHER (Last)		4. DATE OF DEATH (Month) May (Day) 7, (Year) 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Dec. 10, 1884
9. AGE last birthday 70 yrs.		10. KIND OF BUSINESS OR INDUSTRY Sparrows Pt.	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John		14. MOTHER'S MAIDEN NAME ? Von Hohlman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY No. 212-10-8704	
17. INFORMANT AND ADDRESS Mrs. Emelie Rademacher Rosedale			

18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Acute Congestive Heart Failure	
Antecedent cause(s) (b) Arteriosclerotic Cardiac	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Vascular Disease & Hypertension	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1948 to May, 1951, that I last saw the deceased alive on May 6, 1951, and that death occurred at 10:15 P. m., from the causes and on the date stated above.

SIGNATURE L. B. Stevens (Degree or title) M.D.	ADDRESS 3400 Erdman Ave. Balto.	DATE SIGNED 5/9/51
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 5/10/51	NAME OF CEMETERY OR CREMATORY Immanuel
LOCATION (City, town, or county) Balto. Md.	24. FUNERAL DIRECTOR Paul A. Heemann	ADDRESS 6067 Harford RD.
DATE REC'D BY LOCAL REG. 5/10/51	REGISTRAR'S SIGNATURE [Signature]	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A16

544 336

Dr. L. B. Stevens
3400 Erdman Ave.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

04646

1. PLACE OF DEATH- COUNTY <u>Balto Co.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Balto Co. Overlea</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Balto Co. Overlea</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>680I Beech Ave</u>		STREET ADDRESS (If rural, give location) <u>680I Beech Ave</u>	
3. NAME OF DECEASED (Type or Print) <u>Anna C</u>		4. DATE OF DEATH <u>May 7 1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>March 28, 1887</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	9. AGE last birthday <u>64</u> yrs. <u>7</u> Months <u>19</u> Days <u>51</u> Hours <u>1</u> Min.
11. BIRTHPLACE (State or foreign country) <u>Baltimore City</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>Patrick Honey</u>		14. MOTHER'S MAIDEN NAME <u>Mary Sadler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>-</u>	
17. INFORMANT AND ADDRESS <u>Miss Everding 680I Beech Ave Balto. 6 Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) CANCER OF RIGHT OVARYINTERVAL BETWEEN ONSET AND DEATH
1 YR +

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) -(c) -II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION <u>1/15/51</u>	19b. MAJOR FINDINGS OF OPERATION <u>CARCINOMA R. OVARY; PARTIAL OBSTRUCTION Sigmoid; A</u>	20. AUTOPSY? <u>Yes</u> <input type="checkbox"/> <u>No</u> <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/2, 1951, to 5/7, 1951, that I last saw the deceased alive on 5/7, 1951, and that death occurred at 12:45 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>5-10-1951</u>	NAME OF CEMETERY OR CREMATORY <u>Holly Redeemer Cem.</u>	LOCATION (City, town, or county) <u>Balto.</u>	(State) <u>Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR <u>Kassabur Funeral Home 7401 Belair Rd.</u>	ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

Sh. Machine - Ham 2086
6334 Bilan Rd

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04647

Reg. Dist. No.

1. PLACE OF DEATH COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Catonsville		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Catonsville	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 907 Edmondson Ave.		STREET ADDRESS (If rural, give location) 907 Edmondson Ave.	
3. NAME OF DECEASED (Type or Print)	(First) ASBURY	(Middle) F	(Last) RIDEOUT
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Jan. 23, 1880
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardner		10b. KIND OF BUSINESS OR INDUSTRY Landscape	9. AGE last birthday 71 yrs.
13. FATHER'S NAME Asbury Rideout		11. BIRTHPLACE (State or foreign country) Talbot Co. Md.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)		12. CITIZEN OF WHAT COUNTRY? USA	
16. SOCIAL SECURITY No.		14. MOTHER'S MAIDEN NAME Adelaide Wells	
17. INFORMANT Mrs. Anita Rideout Edmondson Ave.		907	

18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	
Immediate cause 442 X Antecedent cause(s)	(a) Cardio Vascular Renal Disease
(b) 131a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	
(c) In aneurism	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY
TIME (Month) (Day) (Year) (Hour) OF INJURY	HOW DID INJURY OCCUR? While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>

22. I hereby certify that I attended the deceased from **Dec 12, 1950**, to **May 28, 1951**, that I last saw the deceased alive on **May 28, 1951**, and that death occurred at **9:28** m., from the causes and on the date stated above.

SIGNATURE [Signature]	DATE SIGNED June 14, 1951
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF June 2, 1951
NAME OF CEMETERY OR CREMATORY Mt. Auburn	LOCATION (City, town, or county) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Holland Funeral Home	ADDRESS 1631 Druid Hill Ave.
DATE REC'D BY LOCAL REG. June 2, 1951	REGISTRAR'S SIGNATURE R.W.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

04648

30

1. PLACE OF DEATH- COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>4703 Sayer Ave. - Apt. C</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>HENRY</u>	(Middle)	(Last) <u>RINN</u>
4. DATE OF DEATH	(Month) <u>May</u>	(Day) <u>19</u>	(Year) <u>1951</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Apr. 1, 1861</u>
9. AGE last birthday <u>90</u> yrs.	If under 1 year Months	If under 24 hrs. Days	If under 24 hrs. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hotel Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Henry Rinn</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Fraitag</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>none</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Mr. Henry F. Rinn - 4703 Sayer Ave.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Arteriosclerotic Cardiovascular Disease

INTERVAL BETWEEN ONSET AND DEATH

15 yrs?

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Jan. 20, 1951, to May 19, 1951, that I last saw the deceased

alive on May 13, 1951, and that death occurred at 12:45 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>5/21/51</u>	<u>Woodlawn Cem.</u>	<u>Woodlawn, Md.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>5/21/51</u>	<u>[Signature]</u>	<u>Wm. J. Dickner & Sons</u>	<u>290836 Balto Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A13

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04649

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Sparrows Point</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Sparrows Point</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7705 Bayfront Rd.</u>		STREET ADDRESS (If rural, give location) <u>7705 Bayfront Rd.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Bettye</u>	(Middle) <u>MAE</u>	(Last) <u>ROBERTSON</u>
4. DATE OF DEATH	(Month) <u>MAY</u>	(Day) <u>27</u>	(Year) <u>1951</u>
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>Jan. 8, 1904</u>
9. AGE last birthday <u>47</u> yrs.		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>buyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Leather Goods</u>	
12. CITIZEN OF WHAT COUNTRY?		14. MOTHER'S MAIDEN NAME <u>Mae Biggs</u>	
13. FATHER'S NAME <u>John D. Robertson</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	
16. SOCIAL SECURITY No. <u>212-12-2347</u>		17. INFORMANT AND ADDRESS <u>Miss Helen B. Robertson - 5501 Woodcrest Ave</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u> <u>2 yrs</u>
Immediate cause <u>171X</u>	(a) <u>Metastatic Carcinoma</u>	
Antecedent cause(s) <u>48a</u>	(b) <u>Carcinoma of cervix</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(c) _____
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 10, 1953, to May 27, 1957, that I last saw the deceased alive on May 27, 1957, and that death occurred at 5:30 A m., from the causes and on the date stated above.

SIGNATURE James J. Means, Jr. D. ADDRESS 5202 St. Sparrows Pt. Rd. Balto. DATE SIGNED 5/27/57

23. BURIAL CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>5/30/51</u>	<u>Lorraine Cem.</u>	<u>Woodlawn, Md.</u>	
DATE REG BY LOCAL REG	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>5/29/57</u>	<u>R. A. Haduch</u>	<u>Wm. J. Pickens & Sons</u>	<u>230698 Balto Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A13

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH- COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD.</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>LODGE FOREST (19)</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>BALTO.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>CARROLL MANOR MAJOR CARROLL A NURSING HOME</u>		STREET ADDRESS (If rural, give location) <u>339 S. LEHIGH ST.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>FRANK</u>	(Middle) <u>EDDRED</u>	(Last) <u>ROSS, SR.</u>
4. DATE OF DEATH	(Month) <u>5</u>	(Day) <u>12</u>	(Year) <u>1951</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>10/31/1894</u>
9. AGE last birthday <u>56</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>SPARROWS PT. MD.</u>	
11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHAS. P. ROSS</u>		14. MOTHER'S MAIDEN NAME <u>KATHERINE I. BAKER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>213-07-2980</u>	
17. INFORMANT AND ADDRESS <u>F. E. ROSS, JR.</u>		<u>U.S. ARMY</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Carcinoma of Right Tonsil

INTERVAL BETWEEN ONSET AND DEATH

6 Mos.

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)TIME (Month) (Day) (Year) (Hour) INJURY OCCURRED OF INJURY While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov., 1950, to May 12, 1951, that I last saw the deceased alive on MAY 12, 1951, and that death occurred at 2:15 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL DATE THEREOF 5/15/51 NAME OF CEMETERY OR CREMATORY LODGE PARK LOCATION (City, town, or county) (State) BALTO. MD.DATE REC'D BY LOCAL REG. May 14-1951 REGISTRAR'S SIGNATURE William M. Kelly Jr. 24. FUNERAL DIRECTOR Walter R. Bradley, Dundalk, MD. ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

523336

REC'D
MAY 15 1961
BUREAU A. B.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

04651

Reg. Dist. No. 42

1. PLACE OF DEATH - COUNTY Baltimore		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE Maryland		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Arbutus		LENGTH OF STAY (In this place) HOSPITAL OR INSTITUTION OR STREET ADDRESS 1236 Maple Ave.		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Arbutus	
3. NAME OF DECEASED (Type or Print) (First) HOWARD (Middle) C. (Last) RUSSELL		4. DATE OF DEATH (Month) May (Day) 21 (Year) 1951			
5. SEX Male		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widower	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Md. Steel Co.		8. DATE OF BIRTH Oct. 18, 1884	
13. FATHER'S NAME Russell		11. BIRTHPLACE (State or foreign country) Md.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. 214-01-9788		14. MOTHER'S MAIDEN NAME Unknown	
17. INFORMANT Arbutus		12. CITIZEN OF WHAT COUNTRY?			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause **Anteriosclerotic Cardiovascular Disease**

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

II. OTHER SIGNIFICANT CONDITIONS
 Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION **19b. MAJOR FINDINGS OF OPERATION**

21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY)		(STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?					

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF May 24/51		NAME OF CEMETERY OR CREMATORY London pk.		LOCATION (City, town, or county) Balto. 29, Md.		(State)	
DATE REC'D BY LOCAL REG. 5-22-51		REGISTRAR'S SIGNATURE <i>[Signature]</i>		24. FUNERAL DIRECTOR <i>[Signature]</i>		ADDRESS 4101 Edmondson Ave.			

MARGIN RESERVED FOR BINDING.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

544336

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Items 5, 6, 7, on:
 FILE NO. G 133 MAY 21 1951

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

04652

1. PLACE OF DEATH COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD.</u> COUNTY <u>BALTO</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>SPARROWS PT.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>SPARROWS PT.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>401 F. STREET</u>		STREET ADDRESS (If rural, give location) <u>401 F. ST.</u>	
3. NAME OF DECEASED (Type or Print) <u>RICHARD FRANCIS SAMS</u>		4. DATE OF DEATH (Month) <u>5</u> (Day) <u>7</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>9/8/1905</u>
9. AGE last birthday <u>45</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SHOT BLASTER</u>	
11. BIRTHPLACE (State or foreign country) <u>W. VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN R. SAMS</u>		14. MOTHER'S MAIDEN NAME <u>LULA FALWELL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>234-05-9520</u>	
17. INFORMANT AND ADDRESS <u>URSULA M. SAMS - WIFE</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) Cardiac failure

Antecedent cause(s)

(b) Posterior coronary occlusion

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

5 weeks

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 31, 1951, to May 7, 1951, that I last saw the deceased alive on May 7, 1951, and that death occurred at 2:15 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

May 9-51

Dawson L. Harber

914 D St., Sparrows Point

5-9-51

BURIAL

5/10/51

OAK LANE

BALTO, MD.

690 333



MARYLAND STATE DEPARTMENT OF HEALTH

04653

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH COUNTY <u>918 Leeds Ave</u> <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD.</u> COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>3010</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Secretary</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>918 Leeds Ave</u>		STREET ADDRESS (If rural, give location) <u>Secretary</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Wilbourn</u>	(Middle) <u>John</u>	(Last) <u>Sard</u>
4. DATE OF DEATH	(Month) <u>May</u>	(Day) <u>18</u>	(Year) <u>1957</u>
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb 23 1878</u>
9. AGE last birthday <u>73</u> yrs.		10. AGE last birthday If under 1 year If under 24 hrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Contractor</u>	
11. BIRTHPLACE (State or foreign country) <u>VA</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>BENJAMIN M. SARD</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET HUBBARD</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY No. <u>215-20-0110 A</u>	
17. INFORMANT <u>Mrs Elsie McMahon Sard</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Pulmonary Tuberculosis</u>			<u>9 mos.</u>
Antecedent cause(s) (b) <u>Arteriosclerosis Cardio Vasc. Dis</u>			<u>?</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Benign Prostatic Hypertrophy</u>			<u>9 mos.</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>Dec. 1950</u>	19b. MAJOR FINDINGS OF OPERATION <u>Benign Prostatic Hypertrophy</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from August, 1950, to May 18, 1957, that I last saw the deceased alive on May 18, 1957, and that death occurred at 11 P.M., from the causes and on the date stated above.

SIGNATURE <u>Earl Pass, M.D.</u>	(Degree or title)	ADDRESS <u>4001 Wilkens Ave</u>	DATE SIGNED <u>5-18-57</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE <u>5-21-1957</u>	NAME OF CEMETERY OR CREMATORY <u>East New Market</u>	LOCATION (City, town, or county) (State) <u>MD</u>
DATE REC'D BY LOCAL REG. <u>May 19 1957</u>	REGISTRAR'S SIGNATURE <u>R.W.</u>	24. FUNERAL DIRECTOR <u>W.B. Thelley & Co</u>	ADDRESS <u>570 358 Ave</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04654

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> <u>or</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Balto, Co.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>6817 Holabird Avenue</u>		STREET ADDRESS (If rural, give location) <u>6817 Holabird Ave</u>	
3. NAME OF DECEASED (First) <u>Minnie</u> (Middle) <u>*</u> (Last) <u>Schlaffer</u>		4. DATE OF DEATH (Month) <u>5-</u> (Day) <u>10-</u> (Year) <u>1951</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>7-23-69</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>81</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Balto - Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Wm. H. Honley</u>		14. MOTHER'S MAIDEN NAME <u>Bertha B. B. B.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>100-1-10000</u>	
17. INFORMANT AND ADDRESS <u>Bertha Schlaffer 6817 Holabird Ave</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Arterio-sclerotic - Cardio Vascular DiseaseINTERVAL BETWEEN ONSET AND DEATH 5 yrs

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Disease(c) Chronic Myocarditis5 yrs

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office bldg, etc.) (CITY OR TOWN) (COUNTY) (STATE)

SUICIDE HOMICIDE INJURY

HOW DID INJURY OCCUR?

TIME (Month) (Day) (Year) (Hour) INJURY OCCURRED While at Work ☐ Not While At work ☐22. I hereby certify that I attended the deceased from Feb 17, 1947, to May 10, 1951, that I last saw the deceased alive on 5-9, 1951, and that death occurred at 4:50 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Davis.
6800 Morningstar Rd.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

Reg. Dist. No. 38

04655

1. PLACE OF DEATH- COUNTY Parkville Balto. MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Md. COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore		CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 3010 Linwood Avenue		STREET ADDRESS (If rural give location) Baltimore	
3. NAME OF DECEASED (Type or Print) Eugene Turner Schmaing		4. DATE OF DEATH (Month) May (Day) 1 (Year) 1951	
5. SEX MALE	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 9-25-97
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret chauffeur		10b. KIND OF BUSINESS OR INDUSTRY Transit co.	9. AGE last birthday 45 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frederick		14. MOTHER'S MAIDEN NAME Mary K	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. -	
17. INFORMANT Marie Schmaing		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) Heart disease, vascular, coronary occlusion Sudden			
Antecedent cause(s) (b) 420.1 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
(c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE Gollin C. Hudson M.D.		DATE SIGNED 5/1/51	
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF 5-5-51	
NAME OF CEMETERY OR CREMATORY Holy Redeemer		LOCATION (City, town, or county) Baltimore (State)	
DATE REC'D BY LOCAL REG. 5-2-51		REGISTRAR'S SIGNATURE A W Deane	
24. FUNERAL DIRECTOR Zelley & Zeller Inc.		ADDRESS 403 S. Wolfe St	

VJT

682516

NOT Dr. H. talked direct to applicant-informant, by phone. 5/51

MARGIN RESERVED FOR BINDING

VS. A15A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04657

Reg. Dist. No. *KX*

1. PLACE OF DEATH COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE _____ COUNTY _____	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Coolgate</i>		CITY (If outside corporate limits, write RURAL and give nearest town) _____	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>7525 Lang St</i>		STREET ADDRESS <i>7525 Lang St</i> (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <i>Harold R.</i> (Middle) <i>Schuster</i> (Last) <i>Schuster</i>	4. DATE OF DEATH <i>May 26</i> 19 <i>51</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>July 21-1917</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Truck Driver</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Transfer</i>	9. AGE last birthday <i>33</i> yrs. If under 1 year: Months _____ Days _____ Hours _____ Min. _____
11. BIRTHPLACE (State or foreign country) <i>Pottsville Penna.</i>		12. CITIZEN OF WHAT COUNTRY? _____	
13. FATHER'S NAME <i>Raymond Schuster</i>		14. MOTHER'S MAIDEN NAME <i>Anna Gibbs</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY No. <i>205-05-4573</i>	
17. INFORMANT <i>Mrs. Helen J. Schuster</i>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <i>Pulmonary edema</i>			<i>2 days</i>
Antecedent cause(s) (b) <i>Chronic glomerular nephritis</i>			<i>6-8 months</i>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <i>Hypertension</i>			<i>6-8 months</i>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Myocardial degeneration</i>			<i>6 months</i>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from *June*, 19*50*, to *May 6*, 19*51*, that I last saw the deceased alive on *May 6*, 19*51*, and that death occurred at *4 p.* m., from the causes and on the date stated above.

SIGNATURE <i>Monis A. Jacobs M.D.</i>	(Degree or title)	ADDRESS <i>1010 Old North RR</i>	DATE SIGNED <i>6/27/51</i>
23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>	DATE <i>May 9/51</i>	NAME OF CEMETERY OR CREMATORY <i>Oak Lawn</i>	LOCATION (City, town, or county) <i>Baltimore</i> (State) _____
DATE REC'D BY LOCAL REG. <i>5/18/51</i>	REGISTRAR'S SIGNATURE <i>L</i>	24. FUNERAL DIRECTOR <i>Philip Herurg Sons</i>	ADDRESS <i>2021 Orleans St</i>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

68352631

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04658

Reg. Dist. No. 31

1. PLACE OF DEATH- COUNTY Baltimore		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Randallstown		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Randallstown	
HOSPITAL OR INSTITUTION OR STREET ADDRESS McDonogh Road		STREET ADDRESS (If rural, give location) McDonogh Road	
3. NAME OF DECEASED (Type or Print)	(First) Minnie	(Middle) C.	(Last) Sellman
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Jan. 2, 1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	9. AGE last birthday 64 yrs yrs.
13. FATHER'S NAME Henry S. Baker		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT AND ADDRESS Mr. Eugene E. Sellman, Randallstown, Md.		17. INFORMANT AND ADDRESS McDonogh Road	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
196X Immediate cause (a) Carcinomatosis		
55b Antecedent cause(s) (b) Cancer of Spine		1949
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1949, to 5/7/57, 1957, that I last saw the deceased alive on 5/7/57, 1957, and that death occurred at 2 A. m., from the causes and on the date stated above.

SIGNATURE Mr. E. J. Martin M.D. ADDRESS Randallstown Harrisonville, Md. DATE SIGNED 5/8/57

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE THEREOF May 9, 1951 NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery LOCATION (City, town, or county) Randallstown, Md. (State)

DATE RECD BY LOCAL REG. 5/8/57 REGISTRAR'S SIGNATURE Mr. E. J. Martin 24. FUNERAL DIRECTOR Wm. L. Lawrence ADDRESS 4510 Liberty Hgts A ve.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 37

04659

1. PLACE OF DEATH COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Texas</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Texas</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Baltimore County Home</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>Frank</u> (Middle) <u>-</u> (Last) <u>Sherman</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>17</u> (Year) <u>1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>July 4, 1867</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farm laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>	9. AGE last birthday <u>83</u> yrs. <u>82</u>
13. FATHER'S NAME <u>William Sherman</u>		14. MOTHER'S MAIDEN NAME <u>Amanda Walker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT AND ADDRESS <u>Baltimore County Home Register, Texas Md.</u>	
16. SOCIAL SECURITY NO.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Atherosclerotic cardiac-vascular disease

Antecedent cause(s)

(b) Hypertension(c) giving rise to the above cause stating the underlying cause last

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death

Cataracts, inguinal hernia, bilateral

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Jan 1, 1951, to May 17, 1951, that I last saw the deceasedalive on May 15, 1951, and that death occurred at 5:30 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Elizabeth B. Sherrill, M.D.Cockeysville, Md. 5/17/51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Removal</u>	<u>May 18 / 51</u>	<u>St. Anthony's Cemetery</u>	<u>Baltimore</u>	<u>Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>May 15 / 51</u>	<u>Wm. J. Whitlock</u>	<u>London Brooks</u>	<u>Sparks Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

STATE OF VERMONT STATE OF NEW YORK

PLANNED PROGRESS

RECEIVED
MAY 22 1981
BUREAU W. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04660

Reg. Dist. No. 30

1. PLACE OF DEATH COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Catonsville</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2536 Old Frederick Road</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Catonsville</u> STREET ADDRESS (If rural, give location) <u>2536 Old Frederick Road</u>	
3. NAME OF DECEASED (First) <u>Catherine</u> (Middle) <u>L.</u> (Last) <u>Short</u>		4. DATE OF DEATH (Month) <u>5</u> (Day) <u>20</u> (Year) <u>51</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>5-17-1911</u>
9. AGE last birthday <u>40</u> yrs.		10. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Detrick, Va.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Albert C. Lichliter</u>		14. MOTHER'S MAIDEN NAME <u>Laura L. Shifflet</u>	
15. SOCIAL SECURITY No. <u>216-10-7958</u>		17. INFORMANT AND ADDRESS <u>Russell H. Short, Catonsville, Md.</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Cerebral Hemorrhage</u>			<u>5 hrs</u>
Antecedent cause(s) (b) <u>14y pulsative Cardiovascular disease</u>			<u>Unknown</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Obesity</u>			
19a. DATE OF OPERATION <u>NONE</u>		19b. MAJOR FINDINGS OF OPERATION <u>NONE</u>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>NONE</u>		22. PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>---</u> m.		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
23. I hereby certify that I attended the deceased from <u>5/19</u> , 19 <u>51</u> , to <u>5/20</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>5/19</u> , 19 <u>51</u> , and that death occurred at <u>1:45 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Cliff Raliff Jr.</u> (Degree or title) <u>M.D.</u>		ADDRESS <u>4605 Edmondman</u> DATE SIGNED <u>Md. 5/20/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>5-24-51</u>	
NAME OF CEMETERY OR CREMATORY <u>Meadowridge Memorial</u>		LOCATION (City, town, or county) (State) <u>Elkridge, Md.</u>	
DATE REC'D BY LOCAL REG. <u>5/20/51</u>		REGISTER'S SIGNATURE <u>V.E. Harry</u>	
24. FUNERAL DIRECTOR <u>F.C. Higinbotham</u>		ADDRESS <u>Ellicott City, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 22 1951
BUREAU A. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04661

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH: COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MD.</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural - Garrys Mills</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>RURAL Garrys Mills, Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Garrys Mills Rd.</u>		STREET ADDRESS (If rural, give location) <u>Garrys Mills Rd.</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>FREDERICK LEWIS SAEGER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>5/13/51</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>Feb. 17, 1869</u>
9. AGE last birthday <u>82</u> yrs.		10. AGE last birthday If under 1 year Months Days Hours Mln.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Police Officer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Police Officer</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Garry Paul Lieber</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Butterbaugh</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-22-6768</u>	
17. INFORMANT AND ADDRESS <u>Son - Mr. Garry Paul Lieber - Garrys Mills, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Coronary Thrombosis

INTERVAL BETWEEN ONSET AND DEATH

2 1/2 yrs

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Jan, 1949, to May 13, 1951, that I last saw the deceased alive on May 1, 1951, and that death occurred at 5:00 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Edwin G. Pierpont, M.D.

8027 LIBERTY RD.

5/13/51

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>5/16/51</u>	<u>Oaklawn</u>	<u>Baltimore, Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>5/15/51</u>	<u>A. W. Krause</u>	<u>Frank H. Newell, Pikesville</u>	<u>773936</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

04662

Reg. Dist. No. 41

1. PLACE OF DEATH COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE WEST VIRGINIA COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) PUNDACK		CITY (If outside corporate limits, write RURAL and give nearest town) STONEY BOTTOM	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1942 CEDAR LANE		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)	(First) CHARLES	(Middle) MOTT	(Last) SIMMONS
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH APR. 15, 1894
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY ROADS	9. AGE last birthday 57 yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME WARICK SIMMONS		14. MOTHER'S MAIDEN NAME GEORGEANNA MC LAUGHLIN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. —	
17. INFORMANT MRS. ELSIE CHURCH		1942 CEDAR LA.	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		2 Mo.	
Immediate cause (a) Coronary Occlusion			
Antecedent cause(s) (b) 420.1 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 94a			
(c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) HOME INJURY INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .			
SIGNATURE (Degree or title) Dr. J. G. Davis M.D. Dist. Exam. - Dundalk - Md.		DATE SIGNED 5/2/51	
23. BURIAL, CREMATION REMOVAL (Specify) REMOVAL	DATE THEREOF MAY 2, 1951	NAME OF CEMETERY OR CREMATORY MC LAUGHLIN	LOCATION (City, town, or county) (State) CASS W. VA
DATE REC'D BY LOCAL REG. MAY 2 - 1951	REGISTRAR'S SIGNATURE William M. Kelly	24. FUNERAL DIRECTOR ADDRESS ULLRICH FUNERAL HOME PUNDACK	

970246 AU.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 4 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *99*

Me 04663

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Port Howard</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Vets. Adm. Hosp. Ft. Howard, Md.</u>		STREET ADDRESS (If rural, give location) <u>1102 Thomsen St.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>CHARLES</u>	(Middle) <u>B.</u>	(Last) <u>SMITH</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>separated</u>	8. DATE OF BIRTH <u>2-6-21</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>student</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>30</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Charlottesville, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Smith</u>		14. MOTHER'S MAIDEN NAME <u>Rosie Baker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>WW-2 Yes WW-2</u>		16. SOCIAL SECURITY No. <u>213-16-3803</u>	
17. INFORMANT AND ADDRESS <u>Clin. Rec. Vets. Adm. Hosp. Ft. Howard, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Pul. Tbc far advanced active bil.

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

INTERVAL BETWEEN ONSET AND DEATH

unknown

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Rheumatic heart disease

8 yrs.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that VA attended the deceased from 5-23, 1950, to 5-23, 1951, that I last saw the deceased

alive on XXXXXXXXXX, and that death occurred at 8:45 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Irving Freeman, M.D. ACTING CHIEF, MEDICAL SERVICE VAH FT. HOWARD, MD. 5-25-51

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>5/29/51</u>	NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	LOCATION (City, town, or county) (State) <u>Balto. Md.</u>
DATE REC'D BY LOCAL REG. <u>5/28/51</u>	REGISTRAR'S SIGNATURE <u>A. W. H. H. H.</u>	24. FUNERAL DIRECTOR <u>Chas. R. Law</u>	ADDRESS <u>802 Madison Ave. Balto. Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

6-21-51 ams

MARYLAND STATE DEPARTMENT OF HEALTH

04664

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. *84*

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Port Howard</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Vets. Adm. Hosp. Ft. Howard, Md.</u>		STREET ADDRESS (If rural, give location) <u>1523 W. Lexington St.</u>	
3. NAME OF DECEASED (First) <u>DAVID</u> (Middle) <u>[REDACTED]</u> (Last) <u>SMITH</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>24</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH <u>4-17-27</u>
9. AGE last birthday <u>24</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Radio repairman unemployed</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Smith</u>		14. MOTHER'S MAIDEN NAME <u>Luvinia Childs</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war, or dates of service) <u>WW-2</u>		16. SOCIAL SECURITY NO. <u>417-22-1170</u>	
17. INFORMANT <u>Clin. Rec. Vets. Adm. Hosp. Ft. Howard, Md.</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Cerebral Hemorrhage

INTERVAL BETWEEN ONSET AND DEATH

24 hours

Antecedent cause(s)

(b) Acute Purpura Hemorrhagicaunknown

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

5/23/51

20. AUTOPSY?

Yes ☒ No ☐21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) May 24 1951 OF INJURYINJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR?

Following operation (for bleeding spleen)

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy ☒, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

5/28/51A. W. HedrickElliott Funeral Home 1129 N. Caroline St.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

076VW

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *38*

Baltimore County
04665

1. PLACE OF DEATH- COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <i>Maryland</i> COUNTY <i>Baltimore</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <i>624 Dumbalk Road</i>	
3. NAME OF DECEASED (Type or Print)	(First) <i>Elizabeth</i> (Middle) <i>S.</i> (Last) <i>Smith</i>	4. DATE OF DEATH	(Month) <i>May</i> (Day) <i>30</i> (Year) <i>1951</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Single</i>	8. DATE OF BIRTH <i>July 1872</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>at home</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>✓</i>	9. AGE last birthday <i>78</i> yrs. If under 1 year: Months <i>8</i> Days <i>1</i> Hours <i>1</i> Min.
11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>		12. CITIZEN OF WHAT COUNTRY? <i>United States</i>	
13. FATHER'S NAME <i>George A. Smith</i>		14. MOTHER'S MAIDEN NAME <i>Catherine Moylan</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY No. <i>1-1-1-1-1-1-1-1-1-1</i>	
17. INFORMANT <i>Charles H. Reier</i>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH <i>Immediate</i> <i>4 weeks</i>
Immediate cause	(a) <i>Coronary Occlusion</i>		
Antecedent cause(s)	(b) <i>Arterio-sclerosis</i>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Apr 30*, 19*51*, to *May 30*, 19*51*, that I last saw the deceased alive on *30 May*, 19*51*, and that death occurred at *3 A.* m., from the causes and on the date stated above.

SIGNATURE *Charles H. Reier M.D.* ADDRESS *6701 York Rd Balt 12* DATE SIGNED *31 May 51*

23. BURIAL, CREMATION REMOVAL (Specify) *Burial* DATE *June 2 1951* NAME OF CEMETERY OR CREMATORY *Cathedral* LOCATION (City, town, or county) *Baltimore* (State) *Md*

DATE REC'D BY LOCAL REG. *5/31/51* REGISTRAR'S SIGNATURE *A W Hargis* 24. FUNERAL DIRECTOR *Rita Weisfeld* ADDRESS *9006 Biddle St*

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

04666

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Illinois</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Garrison</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lake Forest</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Garrison Forest School</u>		STREET ADDRESS (If rural, give location) <u>1600 N. Greenbay Road</u>	
3. NAME OF DECEASED (Type or Print) <u>Wendy Byron Smith</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>21</u> (Year) <u>1951</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Oct 28 1936</u> 14 yrs.
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private School</u>	
11. BIRTHPLACE (State or foreign country) <u>Chicago Ill.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Soloman B. Smith</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Nett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>School Record</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Asphyxiation due to Aspiration
Of Stomach Contents

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Of Stomach Contents

(c)

II. OTHER SIGNIFICANT CONDITIONS
 Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) School
 INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY May 21 1951 10:25 pm.

INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR?

Fall from bed

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

William V. Lovett MD, Asst Medical Examiner Md. May 22 1951

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG. 5/23/51

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Carroll Medical

Henry W. Jenkins & Sons Co 4905 York Rd

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04667

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>	
TOWN <u>Warren Road</u>		TOWN <u>Warren Road</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Warren Road</u>		STREET ADDRESS (If rural, give location) <u>Warren Road</u>	
3. NAME OF DECEASED (First) <u>Granville</u> (Middle) <u>Jennings</u> (Last) <u>Snowden</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>24</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>4 May 1899</u>
9. AGE last birthday <u>52</u> yrs.		10. If under 1 year 24 hrs. 1 year 12 months 1 year 12 months 1 year 12 months	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Oil Distributor</u>	
11. BIRTHPLACE (State or foreign country) <u>Cowling, Yorkshire, England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Snowden</u>		14. MOTHER'S MAIDEN NAME <u>Leah Jennings</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If year, give war or dates of service) <u>1948</u>		16. SOCIAL SECURITY No. <u>217-03-2000</u>	
17. INFORMANT AND ADDRESS <u>Wife - same (Edith G. Snowden)</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Coronary Thrombosis</u>				<u>18 hours</u>	
Antecedent cause(s) (b) <u>Arteriosclerosis</u>				<u>7 years</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>94a</u>					
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 23 May, 1951, to 24 May, 1951, that I last saw the deceased alive on 24 May, 1951, and that death occurred at 11:00 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Walter T. KeesM.D.Cockeysville, Md. 24 May 1951

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>5-28-51</u>		NAME OF CEMETERY OR CREMATORY <u>Parlowood</u>		LOCATION (City, town, or county) <u>Balto. Co. 14, Md.</u> (State) <u>Md.</u>	
DATE REC'D BY LOCAL REG. <u>May 25/51</u>		REGISTRAR'S SIGNATURE <u>M. C. Philcoat</u>		24. FUNERAL DIRECTOR <u>London M. Brooks, Sparks, Md.</u>		ADDRESS <u>390669</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 28 1961
BUREAU U.S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

04668

Reg. Dist. No. 33

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Reisterstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Reisterstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.F.D. #1, Falls Road</u>		STREET ADDRESS (If rural, give location) <u>R.F.D. #1-Falls Rd.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>William</u>	(Middle) <u>David</u>	(Last) <u>Spencer</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Apr. 4, 1884</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>	9. AGE last birthday <u>67</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Warfield-Carroll Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>David Spencer</u>		14. MOTHER'S MAIDEN NAME <u>Harris</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>202-16-0702</u>	17. INFORMANT AND ADDRESS <u>Raymond Stover-Westminster, Md.</u>

18. MEDICAL CERTIFICATION		
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Bullet wound of rt. occipital region of skull</u> Antecedent cause(s) (b) <u>5 min.</u> Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>184</u>		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>		
19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION <u>None</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY <u>Farm</u>	(CITY OR TOWN) (COUNTY) (STATE) <u>R.F.D. Reisterstown, Balto., Md.</u>
TIME (Month) (Day) (Year) OF INJURY <u>5-15-51 7:30 p.m.</u>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Shot with rifle by mistake</u>
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input checked="" type="checkbox"/> , undetermined <input type="checkbox"/> .		
SIGNATURE <u>D.D. Caples, Deputy Med. Exam. M.D.</u>		DATE SIGNED <u>5-16-51</u>
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>5-18-51</u>	NAME OF CEMETERY OR CREMATORY <u>Meadow Branch</u>
DATE REC'D BY LOCAL REG. <u>5-16-51</u>	REGISTRAR'S SIGNATURE <u>Mary B. Ehlers</u>	24. FUNERAL DIRECTOR <u>John E. Myers, Westminster, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 21 1951
ST. PAUL, MINN.

CERTIFICATE OF DEATH

Registered No. 14669

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Maryanna Stamborski

2. DATE
OF
DEATH

May 3 1951

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION 604 S. 46th Street

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

c. Length of stay in Baltimore

60 years

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

604 S. 46th Street

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

May 10 1862

9. AGE (In years last birthday)

89

If Under 1 Year
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

none

11. BIRTHPLACE (State or foreign country)

Poland

12. CITIZEN OF WHAT COUNTRY?

Poland

13. FATHER'S NAME

Rucinski

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Eva Degutis 604 S. 46th Street

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiovascular renal disease

5 yrs.

ANTECEDENT CAUSES

(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

4/42X

II

13/a

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from Apr. 13, 1951, to May 3, 1951, that I last saw the deceased alive on May 3, 1951, and that death occurred at 3:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Geo. J. Guppy

M. D.

23B. ADDRESS

426 S. Patterson Park Ave.

23C. DATE SIGNED

5/5/51

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

May 7 1951

Holy Rosary Cem

Balto, County

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

FUNERAL DIRECTOR

ADDRESS

MAY 6 - 1951

Walter Williams, M.D.

John M. Weber 401 S. Chester St

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

COPY SENT TO ^{Co} LOCAL REGISTRAR No. _____ DATE 5-8-51

RECEIVED

MAY 8 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

04670

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH- COUNTY <u>Parkville</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3005 Edgewood Ave.</u>		MARYLAND LENGTH OF STAY (in this place)		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Parkville</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> STREET ADDRESS (If rural, give location) <u>3005 Edgewood Ave</u>	
3. NAME OF DECEASED (Type or Print) <u>Phillip M. Stuckrath</u>		(First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year) <u>May 18 - 1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <u>Married</u>	8. DATE OF BIRTH <u>Dec. 2 1884</u>	9. AGE last birthday <u>66 yrs.</u>	If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter, Stern & Martin</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>George Stuckrath</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Hofferbert</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-01-9119</u>		17. INFORMANT AND ADDRESS <u>Mrs. Elizabeth Stuckrath, same</u>	
18. MEDICAL CERTIFICATION					
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Life Hemiplegia</u>					<u>14 days.</u>
Antecedent cause(s) (b) <u>Hypertensive Cardiovascular Heart Disease</u>					
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>yes.</u>					
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>5-9</u> , 19 <u>51</u> to <u>5-18</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>5-11</u> , 19 <u>51</u> , and that death occurred at <u>5 A</u> m., from the causes and on the date stated above.					
SIGNATURE <u>Wilbur L. Leary</u>		(Degree or title) <u>M.D.</u>		ADDRESS <u>3025 Belair Rd.</u> DATE SIGNED <u>5-18-51</u>	
23. BURLI CREMATION REMOVAL (Specify) <u>Funeral</u>		DATE THEREOF <u>5/22/51</u>		NAME OF CEMETERY OR CREMATORY <u>Parkwood</u> LOCATION (City, town, or county) (State) <u>Balto, Md.</u>	
DATE REC'D BY LOCAL REG. <u>5/21/51</u>		REGISTRAR'S SIGNATURE <u>Nedine L. J. Luck</u>		24. FUNERAL DIRECTOR <u>5305 Harford Rd.</u> ADDRESS <u>5103 117</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Fearing
3025 Beldi

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

Balt. Co. 04671

1. PLACE OF DEATH COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Balt. Co.	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Rogder Forge LENGTH OF STAY (In this place) 2 weeks		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 224 Hopkins Rd.		STREET ADDRESS (If rural give location) 224 Hopkins Rd.	
3. NAME OF DECEASED (Type or Print) Mildred B. Taylor		4. DATE OF DEATH (Month) 5 (Day) 19 (Year) 1951	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH 11-28-1904
9. AGE last birthday 46 yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator		10b. KIND OF BUSINESS OR INDUSTRY Powder Mill	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Albert C. Taylor		14. MOTHER'S MAIDEN NAME Sarah Ogle	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. 219-14-4533	
17. INFORMANT Mrs. Marie Rix 224 Hopkins Rd.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) **Malignant Neoplasm**

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) **Diabetes Mellitus - arteriosclerotic heart disease**

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Diabetes Mellitus - arteriosclerotic heart disease

19a. DATE OF OPERATION

Feb. 1951

19b. MAJOR FINDINGS OF OPERATION

Metastases to liver & pancreas

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

CITY OR TOWN

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **May 19**, 19**51**, to **May 19**, 19**51**; that I last saw the deceased

alive on **May 19**, 19**51**, and that death occurred at **8:30 p.m.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

Burial

DATE THEREOF

5-22-1951

NAME OF CEMETERY OR CREMATORY

Mt. Carmel

LOCATION (City, town, or county)

Baltimore

(State)

Md.

DATE REC'D BY LOCAL REG.

5/24/51

REGISTRAR'S SIGNATURE

John A. Moran

24. FUNERAL DIRECTOR

John A. Moran

ADDRESS

3000 E. Baltimore St.

690469

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04672

Reg. Dist. No. 48

1. PLACE OF DEATH COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Sparrows Pt</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Sparrows Pt</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>707 J. St.</u>		STREET ADDRESS <u>707 J. St.</u>	
3. NAME OF DECEASED (First) <u>Minnie</u> (Middle) (Last) <u>Traylor</u>		4. DATE OF DEATH (Month) <u>5</u> (Day) <u>26</u> (Year) <u>1951</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>8/7/1897</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>53</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Blanton - 707 J. St.</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Cerebral Hemorrhage</u>		<u>8 days</u>
Antecedent cause(s) (b) <u>Left-sided Hemiplegia</u>		<u>5 yrs.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Arteriosclerosis & Hypertension C.V. Disease</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 15, 1951, to May 26, 1951, that I last saw the deceased alive on May 26, 1951, and that death occurred at 4:45 P.M., from the causes and on the date stated above.

SIGNATURE <u>James J. Mann</u>	(Degree or title) <u>M.D.</u>	ADDRESS <u>5200 St. Sparrows Pt. 192nd Sp. 1951</u>	DATE SIGNED <u>5/28/51</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>5/28/51</u>	NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cem.</u>	LOCATION (City, town, or county) (State) <u>B. A. Co. Md.</u>
DATE REC'D BY LOCAL REG. <u>5/28/51</u>	REGISTRAR'S SIGNATURE <u>R. W. Hedrick</u>	24. FUNERAL DIRECTOR <u>Samuel W. Sullivan Jr.</u>	ADDRESS <u>1011 N. Belington Ave</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 04673 43

1. PLACE OF DEATH- COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Roeselburg</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Balto Co. Roeselburg</u>	
TOWN <u>Roeselburg</u>		TOWN <u>Balto Co. Roeselburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Buck School House Rd.</u>		STREET ADDRESS (If rural, give location) <u>Buck School House Rd #4238</u>	
3. NAME OF DECEASED (Type or Print) <u>John</u> (First) <u>A</u> (Middle) <u>Tayman</u> (Last)		4. DATE OF DEATH <u>MAY</u> (Month) <u>11</u> (Day) <u>1951</u> (Year)	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Sept-16-1894</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gas Plant Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Standard Oil Co</u>	9. AGE last birthday <u>56</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Balto. Co</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joshua T. Tayman</u>		14. MOTHER'S MAIDEN NAME <u>Amanda Chaney</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-10-4360</u>	
17. INFORMANT AND ADDRESS <u>Mrs. J. A. Tayman, Buck School House Rd.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) CORONARY ARTERY THROMBOSIS

INTERVAL BETWEEN ONSET AND DEATH

45 minutes

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) CORONARY ARTERIOSCLEROTIC HEART DISEASE10 mos.

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 7/17, 1950, to 5/11, 1951, that I last saw the deceased alive on 1/26, 1951, and that death occurred at 7:53 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>5/14/51</u>	NAME OF CEMETERY OR CREMATORY <u>Harland M.P. Cem.</u>	LOCATION (City, town, or county) <u>Balto</u>	(State) <u>MD</u>
DATE REC'D BY LOCAL REG. <u>5/14/51</u>	REGISTRAR'S SIGNATURE <u>A.W. Hedrick</u>	24. FUNERAL DIRECTOR <u>Lassalle Funeral Home</u>	ADDRESS <u>7401 Belair Rd. Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

690468

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 04674 4X

1. PLACE OF DEATH- COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Dorchester	
CITY (If outside corporate limits, write RURAL and give nearest town) Fort Howard		CITY (If outside corporate limits, write RURAL and give nearest town) Taylor's Island	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Vet. Adm. Hosp., Ft. Howard, Md.		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) MELVIN	(Middle) LEE	(Last) TRAVERS
4. DATE OF DEATH	(Month) May	(Day) 8	(Year) 1951
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH 4-27-25
9. AGE last birthday 26 yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer C&P Farm Hand		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Travers		14. MOTHER'S MAIDEN NAME Marie C. Stanley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY No. Unknown	
17. INFORMANT AND ADDRESS Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) TUBERCULOSIS, CHRONIC, PULMONARY, FAR ADVANCED			UNKNOWN
Antecedent cause(s) (b) ACTIVE			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY m.		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I hereby certify that VA attended the deceased from Nov. 18 , 19 50 , to May 8 , 19 51 , and that death occurred at 7:15 A. m., from the causes and on the date stated above.			
SIGNATURE Eugene Kittz, M.D.		ADDRESS VAH, Fort Howard, Md. DATE SIGNED 5-8-51	
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF May 11, 1951 NAME OF CEMETERY OR CREMATORY Taylor's Island, Md. LOCATION (City, town, or county) (State) Taylor's Island, Md.	
DATE REC'D BY LOCAL REG. 5-9-51		24. FUNERAL DIRECTOR Charles R. Law 802 Madison Ave. Balto., Md.	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

820/105

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *38*

1. PLACE OF DEATH- COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <i>Maryland</i> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Armcast Nursing Home 812 Regester Avenue</i>		STREET ADDRESS (If rural, give location) <i>2808 N. Calvert Street</i>	
3. NAME OF DECEASED (Type or Print)	(First) <i>Samuel</i>	(Middle) <i>Alexander</i>	(Last) <i>Tubman, Jr.</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>8/17/70</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Transportation U. S. Army Pentagon Bldg.</i>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <i>80</i> yrs.
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Samuel A. Tubman Wash.D.C.</i>		14. MOTHER'S MAIDEN NAME <i>Ann Hammond</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <i>Mrs. Imogen B. Tubman 2808 N. Calvert St.</i>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) *Carcinoma of Rectum*

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

INTERVAL BETWEEN ONSET AND DEATH

2 1/2 years

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) *SUICIDE* PLACE (Home, farm, factory, street, OF office bldg., etc.) *HOMICIDE*

(CITY OR TOWN) (COUNTY) (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY *m.*

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

20. AUTOPSY?

Yes ☐ No ☒

22. I hereby certify that I attended the deceased from *Oct*, 19*43*, to *May 14*, 19*51*, that I last saw the deceased alive on *May 13*, 19*51*, and that death occurred at *2:30 P.* m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify) *Burial*

DATE THEREOF *5/17/51*

NAME OF CEMETERY OR CREMATORY *Druid Ridge*

LOCATION (City, town, or county) *Pikesville, Md.*

(State)

DATE REC'D BY LOCAL REG. *5-17-51*

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

The 25. Meades and Son 505 N. Calvert St.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A16

WV 916

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 31

04676

1. PLACE OF DEATH COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Granite</u> TOWN <u>Granite</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Old Court-Road</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Granite</u> TOWN <u>Granite</u> STREET ADDRESS (If rural, give location) <u>Old Court-Road</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>John</u>	(Middle) <u>Archibald</u>	(Last) <u>Trail</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept. 28 1898</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>	9. AGE last birthday <u>52</u> yrs. <u>29</u> Months <u>29</u> Days <u>19</u> Hours <u>51</u> Min.
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John B. Trail</u>		14. MOTHER'S MAIDEN NAME <u>Ellen E. Haight</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs Emma E. Trail - Granite, Md</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a) Acute dilatation of Heart
(b) Chronic Valvular Heart Disease
(c)

INTERVAL BETWEEN ONSET AND DEATH

1/2 hrII. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office hldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from....., 1948, to 5/29/1957; that I last saw the deceased alive on 5/27/1957, and that death occurred at 11:30 P. m., from the causes and on the date stated above.

SIGNATURE <u>Wm. E. Martin</u>	(Degree or title) <u>M.D. Randallston</u>	ADDRESS <u>Md</u>	DATE SIGNED <u>5/30/57</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>6-2-51</u>	NAME OF CEMETERY OR CREMATORY <u>Granite Presbyterian</u>	LOCATION (City, town, or county) <u>Granite, Md.</u> (State)
DATE REC'D BY LOCAL REG. <u>5/30/57</u>	REGISTRAR'S SIGNATURE <u>Wm. E. Martin</u>	24. FUNERAL DIRECTOR <u>Wm. Haight - Hydesville, Md.</u>	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU OF

JUN 4 1967

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Item 4, 9, on:
 MM NO. G 132 MAY 15 1951

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY BALTIMORE CITY (If outside corporate limits, write RURAL and give nearest town) RURAL WOODLAWN TOWN RIDGE RD. HOSPITAL OR INSTITUTION OR STREET ADDRESS RIDGE RD.		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Md. COUNTY BALTO. CITY CITY (If outside corporate limits, write RURAL and give nearest town) 2100 BOONE ST. - Balto. City. TOWN BOONE ST. STREET ADDRESS 2100 BOONE ST. - BALTO. CITY	
3. NAME OF DECEASED (Type or Print) FRANCIS (First) PATRICK (Middle) USHER SR. (Last)		4. DATE OF DEATH May (Month) 1 (Day) 1951 (Year)	
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, OR Married	8. DATE OF BIRTH Aug. 6/1878
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AGENT for Chesapeake & Delaware		10b. KIND OF BUSINESS OR INDUSTRY Shipping	9. AGE last birthday 72 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME RICHARD USHER		14. MOTHER'S MAIDEN NAME Mary Romy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-03-7850	
17. INFORMANT AND ADDRESS JAMES R. USHER - Ridge Rd, Woodlawn, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) **SUICIDE** PLACE (Home, farm, factory, street, OF office bldg., etc.) **INJURY**

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY?

Yes ☐ No ☐

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **JAN. 1950**, to **5/1**, 1951, that I last saw the deceased alive on **5/1**, 1951, and that death occurred at **11 P.M.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

3805465118 *Burym Oak Ave*

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

04678

1. PLACE OF DEATH COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Catonsville		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Catonsville	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 2208 Pleasant View Ave.		STREET ADDRESS (If rural, give location) 2208 Pleasant View Ave.	
3. NAME OF DECEASED (Type or Print)	(First) Jessie	(Middle) Casswell	(Last) Walsh
4. DATE OF DEATH	(Month) 5	(Day) 29	(Year) 1951
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married	8. DATE OF BIRTH 7-13-1905
9. AGE last birthday 45 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home	10b. KIND OF BUSINESS OR INDUSTRY House	11. BIRTHPLACE (State or foreign country) Oella, Md.
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME William E. Robinson	
14. MOTHER'S MAIDEN NAME Sophia Engle		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 213-09-6262		17. INFORMANT AND ADDRESS Richard A. Walsh, Catonsville, Md.	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

162X Immediate cause

(a) Primary Bronchogenic Carcinoma of lung

1 year

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) none

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

none

19a. DATE OF OPERATION June 4-50	19b. MAJOR FINDINGS OF OPERATION Primary Bronchogenic Carcinoma Rt middle lobe lung	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE	(Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 1, 1950, to 5-29, 1951, that I last saw the deceased

alive on 5-29, 1951, and that death occurred at 7:45 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 6-2-51	NAME OF CEMETERY OR CREMATORY Good Shepherd	LOCATION (City, town, or county) Ellicott City, Md.	(State)
DATE REC'D BY LOCAL REG. 5/31/51	REGISTRAR'S SIGNATURE V E. Harry	24. FUNERAL DIRECTOR F.C. Higinbotham	ADDRESS Ellicott City, Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN - 4 1961
BUREAU W. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

04679

1. PLACE OF DEATH- COUNTY <u>Balta. Co.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD</u> COUNTY <u>Balta</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Balta Co.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Victory Villa</u>	
TOWN <u>Balta Co.</u>		TOWN <u>Victory Villa</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>65. Henderson Rd.</u>		STREET ADDRESS (If rural, give location) <u>65. Henderson Rd.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Barbara</u> (Middle) <u>A</u> (Last) <u>WATKINS</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>4</u> (Year) <u>1951</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Dec. 4 - 1865</u>
9. AGE last birthday <u>85</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Willard Holt 65. Henderson Rd. Balt. 20.</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Uremia</u>		<u>6 weeks</u>	
Antecedent cause(s) (b) <u>Arteriosclerotic Heart Disease</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Chronic Pyelitis</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>none</u>			
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) <u>-</u> PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>-</u> (CITY OR TOWN) <u>-</u> (COUNTY) <u>-</u> (STATE) <u>-</u>			
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>-</u> INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR? <u>-</u>	
22. I hereby certify that I attended the deceased from <u>March 28</u> , 19 <u>51</u> , to <u>May 4</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>May 4</u> , 19 <u>51</u> , and that death occurred at <u>11:05 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Irving Beck M.D.</u>		DATE SIGNED <u>5/5/51</u>	
ADDRESS <u>901 Funerage Ave Baltimore 20</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u> DATE THEREOF <u>5/6/51</u>		NAME OF CEMETERY OR CREMATORY <u>Lovimier Cem.</u> LOCATION (City, town, or county) <u>Cape Girardeau Mo</u> (State) <u>Mo</u>	
DATE REC'D BY LOCAL REG. <u>May 5th 1951</u> REGISTRAR'S SIGNATURE <u>R.W.</u>		24. FUNERAL DIRECTOR <u>Lovimier Funeral Home 7401 Belair Rd.</u> ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 T

Sh. Back. Fuselager Compass Rd. 901

MARYLAND STATE DEPARTMENT OF HEALTH

04680

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *42*

1. PLACE OF DEATH COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Md.</i> COUNTY <i>Baltimore</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Halethorpe</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Halethorpe</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location) <i>5325 Oakland Rd.</i>	
3. NAME OF DECEASED (Type or Print) <i>Fredrick C. Wetts</i>		4. DATE OF DEATH (Month) <i>May</i> (Day) <i>30</i> (Year) <i>1951</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>W.</i>	7. SINGLE, MARRIED, WIDOWER, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Sept. 2, 1893</i>
9. AGE last birthday <i>57</i> yrs.		10. BIRTHPLACE (State or foreign country) <i>Md.</i>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sanitation operator</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>unknown</i>		14. MOTHER'S MAIDEN NAME <i>unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>		16. SOCIAL SECURITY No. <i>2-18-05-6502</i>	
17. INFORMANT <i>Mrs. Laverda Deughter</i>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <i>Pulmonary Edema</i>		<i>5 days</i>	
Antecedent cause(s) (b) <i>Bronchial Asthma</i>		<i>3 yrs</i>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <i>Arteriosclerotic C-V Disease</i>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>May</i> , 19 <i>48</i> , to <i>May</i> , 19 <i>51</i> , that I last saw the deceased alive on <i>May 30</i> , 19 <i>51</i> , and that death occurred at <i>6:45 P.</i> m., from the causes and on the date stated above.			
SIGNATURE <i>Morris W. Steinberg</i>		DATE SIGNED <i>June 1, 1951</i>	
23. BURIAL, CREMATION REMOVAL (Specify) <i>Buried</i>		NAME OF CEMETERY OR CREMATORY <i>Greenwood Cemetery</i>	
DATE REC'D BY LOCAL REG. <i>6/1/51</i>		ADDRESS <i>410 N. Hilton St Baltimore, Md.</i>	
REGISTRAR'S SIGNATURE <i>A. W. Hedrick</i>		FUNERAL DIRECTOR <i>Benjamin E. Perry</i>	
		ADDRESS <i>5246 Carroll Rd. 761 VVV</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING
MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

BIRTH NO.				CERTIFICATE OF DEATH		Registered No. <u>50</u> <u>04681</u>	
1. NAME OF DECEASED (Type or Print) <u>George Marion Whiteley</u>				2. DATE OF DEATH <u>May 5, 1951</u>			
3. PLACE OF DEATH: A. Baltimore City, Maryland <u>Kensington, Balto. Co. Md</u>				4. USUAL RESIDENCE (Where deceased lived if institution: residence before admission) A. STATE <u>Maryland</u> COUNTY <u>Baltimore</u>			
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>4216 KENSINGTON RD.</u>				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>(rural) Kensington.</u>			
c. Length of stay in Baltimore Yrs. <u>—</u> Mos. <u>—</u> Days <u>—</u>				D. STREET ADDRESS (If rural, give location) <u>4216 Kensington Road.</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>FEB. 27, 1897</u>		9. AGE (In years last birthday) <u>54</u>	10. Under 1 Year Months: <u>—</u> Days: <u>—</u>	11. Under 24 Hours Hours: <u>—</u> Min. <u>—</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRAFFIC MGR.</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>TUGBOAT</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>—</u>
13. FATHER'S NAME <u>JOSEPH WHITELEY</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE DWYER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>YES</u> <u>W.W.I</u>			16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT ADDRESS <u>Mr. Gertrude Whiteley - 4216 Kensington Rd.</u>		
18. CAUSE OF DEATH						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Coronary occlusion & heart block</u>						<u>18 hrs.</u>	
DUE TO ANTECEDENT CAUSES (B) <u>Myocarditis</u>						<u>7 mos.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE. (A) STATING THE UNDERLYING CONDITION LAST. <u>420.1</u> <u>94a</u> (C) <u>arthritis</u>						<u>1 yr.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>—</u>							
19A. DATE OF OPERATION <u>—</u>		19B. MAJOR FINDINGS OF OPERATION <u>—</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) <u>—</u>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>—</u>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>			
22. I hereby certify that I attended the deceased from <u>October 5, 1950</u> , to <u>May 5, 1951</u> , that I last saw the deceased alive on <u>May 5, 1951</u> , and that death occurred at <u>1:30 Am.</u> , from the causes and on the date stated above.							
23A. SIGNATURE <u>George H. Jaggott</u> M. D.				23B. ADDRESS <u>3812 Greenmount Ave.</u>		23C. DATE SIGNED <u>May 5, 1951</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5-8-51</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Waters Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
DATE RECEIVED BY LOCAL REGISTRAR <u>5/7/51</u>		REGISTRAR'S SIGNATURE <u>J. E. Harvey</u>		25. FUNERAL DIRECTOR <u>George H. Jaggott, Catonsville, Md.</u>		ADDRESS <u>380 5th</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04682

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Sparrow's Point</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Sparrow's Point</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>823 J. St.</u>		STREET ADDRESS (If rural, give location) <u>823 J. St.</u>	
3. NAME OF DECEASED (Type or Print) <u>Rev James E. White</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>8</u> (Year) <u>1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>married June 29, 1876</u>	8. DATE OF BIRTH <u>June 29, 1876</u> yrs. <u>80</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired (Painter)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Painting</u>	
11. FATHER'S NAME <u>Nicholas White</u>		12. CITIZEN OF WHAT COUNTRY? <u>Harford md</u>	
13. MOTHER'S NAME <u>Angeline</u>		14. BIRTHPLACE (State or foreign country) <u>Harford md</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Ida Clara White 823 J. St</u>	
17. INFORMANT AND ADDRESS <u>Ida Clara White 823 J. St</u>		18. MEDICAL CERTIFICATION	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a)

(b)

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN ONSET AND DEATH

4 years

6 mos.

5 days

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY?

Yes ☐ No ☐

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 1, 1950 to May 7, 1951, that I last saw the deceased

alive on May 7, 1951, and that death occurred at 11:45 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE RECD BY LOCAL REG

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04683

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Md. COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Woodlawn		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Woodlawn	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 5517 Windsor Mill Rd.		STREET ADDRESS (If rural, give location) 2120 Sunbriar Ave.,	
3. NAME OF DECEASED (Type or Print) Ellen Catherine Williamson		4. DATE OF DEATH (Month) May (Day) 7 (Year) 1951	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Sept 18, 1871
9. AGE last birthday 79 yrs.		10. CITIZEN OF WHAT COUNTRY? 12. CITIZEN OF WHAT COUNTRY?	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Patrick Martin		14. MOTHER'S MAIDEN NAME Mary	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY No. none	
17. INFORMANT AND ADDRESS Wm. Williamson 2120 Sunbriar Ave.,			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Ante Sahlsson		5 years
Antecedent cause(s) (b) Infectd Gall Bladder		1 week
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **May 7, 1951**, to **May 7, 1951**, that I last saw the deceased alive on **May 7, 1951** and that death occurred at **8:41** m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 5-10-1951	NAME OF CEMETERY OR CREMATORY Lorraine Park	LOCATION (City, town, or county) Woodlawn Md.
DATE REC'D BY LOCAL REG 8/9/51	REGISTRAR'S SIGNATURE R. H. Hedrick	24. FUNERAL DIRECTOR G. Howard Strong	ADDRESS 3207 W. North Ave.,

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

04684

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Sheppard and Enoch Pratt Hosp.</u>		STREET ADDRESS (If rural, give location) <u>19 W. Lexington St.</u>	
3. NAME OF DECEASED (First) <u>Stella</u> (Middle) <u>E.</u> (Last) <u>Wyman</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>12</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>June 19, 1882</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>68</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Mto.
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Gerson Eiseman</u>		14. MOTHER'S MAIDEN NAME <u>Rosa Eiseman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>HOSPITAL RECORDS</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Chronic myocardial degeneration

INTERVAL BETWEEN ONSET AND DEATH

10 yr +

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Generalized arteriosclerosis

10 yr +

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Paranoid Schizophrenia

20 yr

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify)

SUICIDE
HOMICIDE
TIME (Month) (Day) (Year) (Hour)

PLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

OF INJURY

INJURY OCCURRED While at Work Not White At work

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 29, 1943, to May 12, 1951, that I last saw the deceased

alive on May 12, 1951, and that death occurred at 3:35 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE REC'D BY LOCAL REG. 5/14/51

DATE THEREOF

5/14/51

NAME OF CEMETERY OR CREMATORY

Bald Hebrew Cemetery

LOCATION (City, town, or county)

Baltimore, Md

(State)

24. FUNERAL DIRECTOR

David Sordheim

ADDRESS

1903 E. ...

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04685

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD.</u> COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>CATONSVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>YIY GARDEN RIDGE RD.</u>		STREET ADDRESS (If rural, give location) <u>YIY GARDEN RIDGE RD.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>JEAN</u>	(Middle) <u>T</u>	(Last) <u>YEAGER</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	4. DATE OF DEATH Month <u>MAY</u> Day <u>3</u> Year <u>1951</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	8. DATE OF BIRTH <u>DEC. 6/1908</u>	9. AGE last birthday <u>3Y</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>CONN.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>JOHN KAY</u>		14. MOTHER'S MAIDEN NAME <u>JESSICA PANGBORN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u> </u>	
17. INFORMANT AND ADDRESS <u>JOHN W. YEAGER-YIY GARDEN RIDGE RD.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Cirrhosis of Liver Secondary to</u>		<u>1 mo.</u>
Antecedent cause(s) <u>Liver metastasis</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Melanoma - Sarcocoma - Primary site skin</u>		<u>3 mo.</u>
(c) <u>Generalized Metastasis</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 15, 1951, to May 3, 1951, that I last saw the deceased alive on April 15, 1951, and that death occurred at 1 P.M. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE <u>5-7-51</u>	NAME OF CEMETERY OR CREMATORY <u>BALTO. NATIONAL</u>	LOCATION (City, town, or county) <u>BALTO.</u>	(State) <u>MD.</u>
DATE REC'D BY LOCAL REG. <u>5/7/51</u>	REGISTRAR'S SIGNATURE <u>V. E. Harris</u>	24. FUNERAL DIRECTOR <u>George B. Harley - Catonsville, Md.</u>	ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A16

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Doctor

Will you please sign
& leave in social box.

Will pick it up tomorrow.

Forley

RECEIVED

MAY 9 1961

BUREAU W.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04686

Reg. Dist. No. 30

1. PLACE OF DEATH COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) Catonsville		CITY (If outside corporate limits, write RURAL and give nearest town) Catonsville	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 4 S. Rolling Road		STREET ADDRESS (If rural give location) 4 S. Rolling Road	
3. NAME OF DECEASED (Type or Print)	(First) Emma A. (Middle) Yeisley (Last)	4. DATE OF DEATH	(Month) May (Day) 11 (Year) 19 51
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single	8. DATE OF BIRTH Feb. 17, 1859
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 92 yrs.
13. FATHER'S NAME Jacob Yeisley		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		12. CITIZEN OF WHAT COUNTRY? U. S.	
16. SOCIAL SECURITY No.		14. MOTHER'S MAIDEN NAME Elizabeth L. Springer	
17. INFORMANT Mrs. Alexander P. Rusk - 128 Woodlawn Ave.			

18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) arterio sclerosis - Broncho pneumonia	3 days
Antecedent cause(s) (b) arterio sclerosis	
(c)	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
21. ACCIDENT (Specify) SUICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **Dec 30, 1930**, to **May 11, 1951**, that I last saw the deceased alive on **May 11, 1951**, and that death occurred at **2 P** m., from the causes and on the date stated above.

SIGNATURE **[Signature]** ADDRESS **20 E. Preston St.** DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 5 - 14 - 51	NAME OF CEMETERY OR CREMATORY Greenmount	LOCATION (City, town, or county) Baltimore, Md. (State)
DATE REC'D BY LOCAL REG. 5/14/51	REGISTRAR'S SIGNATURE [Signature]	24. FUNERAL DIRECTOR John O. Mitchell & Sons, Inc.	ADDRESS 1900 Eutaw Place Baltimore, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.